S. Hrg. 98-1262

TEENAGE SUICIDE

HEARING

BEFORE THE

SUBCOMMITTEE ON JUVENILE JUSTICE

OF THE

COMMITTEE ON THE JUDICIARY

UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

ON

OVERSIGHT ON THE FACTORS THAT MAY LEAD TO TEENAGE SUICIDE, AND WHAT MAY BE DONE TO PREVENT THAT TRAGEDY

OCTOBER 3, 1984

Serial No. J-98-143

Printed for the use of the Committee on the Judiciary

U.S. GOVERNMENT PRINTING OFFICE
40-196 O
WASHINGTON : 1985

S521-49

COMMITTEE ON THE JUDICIARY

STROM THURMOND, South Carolina, *Chairman*

CHARLES McC. MATHIAS, Jr., Maryland
PAUL LAXALT, Nevada
ORRIN G. HATCH, Utah
ROBERT DOLE, Kansas
ALAN K. SIMPSON, Wyoming
JOHN P. EAST, North Carolina
CHARLES E. GRASSLEY, Iowa
JEREMIAH DENTON, Alabama
ARLEN SPECTER, Pennsylvania

JOSEPH R. BIDEN, Jr., Delaware
EDWARD M. KENNEDY, Massachusetts
ROBERT C. BYRD, West Virginia
HOWARD M. METZENBAUM, Ohio
DENNIS DeCONCINI, Arizona
PATRICK J. LEAHY, Vermont
MAX BAUCUS, Montana
HOWELL HEFLIN, Alabama

Vinton DeVane Lide, *Chief Counsel and Staff Director*
Deborah K. Owen, *General Counsel*
Deborah G. Bernstein, *Chief Clerk*
Mark H. Gitenstein, *Minority Chief Counsel*

Subcommittee on Juvenile Justice

ARLEN SPECTER, Pennsylvania, *Chairman*

JEREMIAH DENTON, Alabama
CHARLES McC. MATHIAS, Jr., Maryland

HOWARD M. METZENBAUM, Ohio
EDWARD M. KENNEDY, Massachusetts

Mary Louise Westmoreland, *Chief Counsel and Staff Director*
Ellen Broadman, *Minority Chief Counsel*

CONTENTS

OPENING STATEMENT

Page

Specter, Hon. Arlen, a U.S. Senator from the State of Pennsylvania, chairman, Subcommittee on Juvenile Justice 1

CHRONOLOGICAL LIST OF WITNESSES

Scherago, Marcia and Robert, Burke, VA; "Julie Smith" accompanied by her mother, "Patricia Smith," District of Columbia metropolitan area 2

Ownby, H., criminal district attorney, Collin County courthouse, McKinney, TX; Dr. Alan L. Berman, Ph.D., professor of psychology, the American University, and president of the American Association of Suicidology, on behalf of the American Psychological Association, Washington, DC; and Myra R. Herbert, M.S.W., Coordinator, School Social Work Services, Fairfax County Public Schools, Fairfax, VA 21

ALPHABETICAL LISTING AND MATERIALS SUBMITTED

Berman, Alan L.:
- Testimony 30
- Prepared statement 33

Herbert, Myra R.:
- Testimony 45
- Prepared statement 48

Ownby, H.:
- Testimony 21
- Prepared statement 25

Scherago, Marcia:
- Testimony 2
- Prepared statement 4

Smith, Julie: Testimony 12

Smith, Patricia: Testimony 15

APPENDIX

Letter from Andrew C. Teter to the Subcommittee on Juvenile Justice, October 29, 1984 59

"Adolescent Suicide and the Classroom Teacher," by Patrick C. McKenry, Carl L. Tishler, and Karen L. Christman, from the Journal of School Health, March 1980 60

California Senate Bill No. 947—Schools: Youth suicide prevention school programs 63

"Suicide in Adolescence: Prevention and Treatment," by Norman L. Farberow, excerpts from Golombek, H. & Garfinkel, B.D., "The Adolescent and Mood Disturbance," N.Y.: International Universities Press, 1983 68

TEENAGE SUICIDE

WEDNESDAY, OCTOBER 3, 1984

U.S. SENATE,
SUBCOMMITTEE ON JUVENILE JUSTICE,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:05 a.m., in room 226, Dirksen Senate Office Building, Hon. Arlen Specter (chairman of the subcommittee) presiding.

Staff present: Mary Louise Westmoreland, chief counsel and staff director; Eva Carney, counsel; and Tracy McGee, chief clerk.

OPENING STATEMENT OF HON. ARLEN SPECTER, A U.S. SENATOR FROM THE STATE OF PENNSYLVANIA, CHAIRMAN, SUBCOMMITTEE ON JUVENILE JUSTICE

Senator SPECTER. Good morning, ladies and gentlemen.

We will begin this hearing of the Juvenile Justice Subcommittee of the Judiciary Committee.

Our hearing this morning involves the issue of teenage suicides, where there has been a very dramatic increase over the past 25 years, and particularly disconcerting have been the clusters of suicides which have occurred in communities such as Fairfax County, VA, in 1980 and 1981, and in Plano, TX, earlier this year.

The witnesses today will focus on the factors that may lead to teenage suicide, and also on what might be done to prevent that tragedy, and what the Federal Government is currently doing on the subject in a variety of ways, and what action the Federal Government might undertake to expand its activities in this important regard.

There have already been legislative initiatives by two States, California and Florida, mandating suicide prevention programs, and New York has just earmarked some $3,500,000 for suicide awareness and a prevention program in schools statewide.

This is another one of the burgeoning problems that we find among the young people of our country, and the Juvenile Justice Subcommittee has been reviewing the situation for some time, and thought these hearings to be an appropriate way to focus in on this problem, with a view toward some expanded Federal legislative corrective action.

I would like to call as our first witnesses today Marcia and Robert Scherago, who were parents of a child who fell victim to suicide as a teenager; and also, "Patricia and Julie Smith," who will share with us a situation which they have experienced. Patricia Smith is the mother of Julie, who has attempted suicide.

If you would come forward, I would appreciate it at this time.

Mr. and Mrs. Scherago, let us begin with you. We know how difficult it is for you to appear here and discuss this subject. We appreciate your being willing to come here as a means of shedding light on this important subject, which may prevent other people from undergoing the trauma which has befallen your family.

Mr. Scherago, will you begin, or will you have Mrs. Scherago go first?

STATEMENTS OF A PANEL CONSISTING OF MARCIA AND ROBERT SCHERAGO, BURKE, VA; "JULIE SMITH" ACCOMPANIED BY HER MOTHER, "PATRICIA SMITH," DISTRICT OF COLUMBIA METROPOLITAN AREA

Mrs. SCHERAGO. I have been elected.

May I read my statement?

Senator SPECTER. By all means.

Mrs. SCHERAGO. I am speaking for myself at this point, since there was not time for my husband to also submit a statement.

I am a bereaved mother, who is also a licensed social worker in Virginia, working as a family and grief therapist in a private setting.

I understand that one of the purposes of this hearing is to investigate a possible link between teenage suicide and a victim's involvement in the juvenile justice system and/or child abuse.

While I believe such a connection may exist, our 16-year-old son, Steven, killed himself 4 years and 2 months ago today, and he did not fit this connection.

I am now actively involved in a self-help group for bereaved parents, the Compassionate Friends, and I heard the same from other parents of suicides.

Professionally, I have worked with people who have seriously considered suicide as a viable alternative to living with emotional pain. They have exhibited some common characteristics that my son also showed, but the links appear to be the exception rather than the expected. Substance abuse is sometimes involved, but again, it is in the minority.

If this investigation only focuses on factors of substance abuse, potential victims might be ignored and go undetected. My son and all the thousands of other beautiful children who did not know that there was another option dealing with emotional pain and death will have died in vain.

A silent killer lives in this society and its allies are some of the most influential people in our children's lives, including parents, family, friends, teachers, clergy, therapists, doctors, lawyers, journalists and lawmakers. This killer lives inside each of us and answers to the names of ignorance, denial and stigma.

Frightened people resort to denial as a means of protecting themselves and making reality less threatening. When denial wears thin, stigma is whipped into action to protect their vulnerability. Myths about reality are created to help maintain this line of defense.

Such is the case, I believe, regarding teenage suicides. Ours is a death-denying society that appears to ignore the scores of children who die each year at their own hands as dismissing them as being "zonked" on something, mentally ill, or having bad parents.

Each time I speak of my son's death, I deal with pain, just as I am dealing with it as I speak to you today. I am a parent who is acutely aware of the need to remove the wraps from the last taboo subject in this society—death—and more specifically, teenage suicide.

We expect children to respond on our level, as adults. We do not know how to interpret their behaviors, which usually say more than the words, as such, we miss their subtle signals and messages. They get into emotional trouble, and often flounder around looking for their lost self-esteem.

As it was with our son Steven, often these children are unusually sensitive, caring people with high, unreachable expectations. They are perfectionists, with emotional and sometimes physical immaturity. They may also feel isolated or rejected by their peers, although seeking acceptance. Steven talked about suicide, but was ignored and not taken seriously.

A key factor for these at risk children is that they may suffer what they perceive as a significant loss, such as the breakup of a boy-girl relationship, or poor grades. For some unknown reason, their pain is so overwhelming that the only solution seems to be to end the pain by ending their lives.

Perhaps indigenous depression is one cause. Also, most adults do not believe children experience significant depression.

My suggestions include educating these allies of this silent killer, to listen and look more closely to the real signs and symptoms that most teenagers exhibit.

Research into the whole range of factors contributing to teenage suicide is needed. Food may be a contributing factor in the increase of teenage suicide. Our foods are processed and sprayed differently from those of my generation.

If we are to stem this epidemic, we must act now, or more of us will be burying our children.

Thank you.

Senator SPECTER. Thank you very much, Mrs. Scherago.

[The prepared statement of Mrs. Scherago follows:]

PREPARED STATEMENT OF MARCIA G. SCHERAGO

The perspective contained in this statement is that of a bereaved mother, who is also a licensed social worker in Virginia working as a family and grief therapist in a private setting.

I am aware that one of the purposes of this hearing is to investigate a possible link between teenage suicide and a victim's involvement in the juvenile justice system and/or child abuse.

While I believe that such a connection may exist, our sixteen-year-son Steven killed himself four years and two months ago today, and he did not fit this connection.

Since his death I have become acquainted with bereaved parents of suicides from all over the United States, as I am actively involved in a self-help group for bereaved parents, The Compassionate Friends.

Professionally, I have worked with and am currently working with young people (up to 25 years of age) who have attempted or have seriously considered suicide as a viable alternative to living with emotional pain. These clients have exhibited some common characteristics that my son also showed, but the possible link previously identified appears to be the exception rather than the expected. Drugs and alcohol are sometimes involved, but again they are in the minority.

I Hope your hearing uncovers information to support or deny this link, for either way the subject will get sorely needed attention, publicity, and perhaps increased awareness, resulting in the saving of children's lives. This investigation heartens me because teenage suicide is the number two killer of youths, ages 16 to 24, in this country, and if automobile accidents were investigated thoroughly, suicide would surely rank number one. Obviously it has reached epidemic proportions, increasing two hundred per cent in the last twenty years.

Although teenage suicide is broad in its scope and you may have found a starting place, it would be a waste of your time and my money if you looked no further than this link. You see, this link narrows your investigation so, that potential victims would be ignored and could go undetected, and my son and all the thousands of other beautiful children who did not know that there was another option to dealing with emotional pain than death will have died in vain.

There is a silent killer that lives in this society and its unwitting allies are some of the most influential people in children's lives. This killer's allies include parents, family, friends, educators, clergy, therapists, doctors, lawyers, journalists, broadcasters and law-makers. This killer lives inside each of us and answers to the names of ignorance, denial and stigma. When human beings are frightened they often resort to denial as a means of protecting themselves and making reality less threatening. When denial wears thin, then stigma is whipped into action so that their vulnerability is not exposed. Myths about reality are usually spawned and perpetuated to help maintain the line of defense. Such is the case, I believe, regarding teenage suicide. Ours is a death-denying society that appears to ignore the scores of children who die each year at their own hands by dismissing them as being "zonked" on something, mentally ill, or having bad parents. These are misconceptions, and if they are permitted to continue the teenage suicide epidemic will worsen because of a lack of understanding by all the silent killer's allies and because we did not understand them as cries for help.

During the past four years and two months I have been refused the opportunity to speak to PTA's, doctors, nurses, and hospital personnel, to name just a few groups, not because my fee was too high, as there is no fee, but because, I believe, the subject of teenage suicide was too threatening, too close to home. When a teenager's death is reported in the news it is a nameless face -

someone we don't know - but when the face belongs to someone we do know then it is getting too close. I represent that threat.

Each time I speak of my son's death I deal with pain, just as I am dealing with it as I speak to you today. I am a parent who is acutely aware of the need to remove the wraps from the last taboo subject in this society - death - and more specifically, teenage suicide. Our children are trying to tell us that two cars and three color television sets are not enough for a happy home life. Affluence is not the panacea to what ails our distressed youth. Learning to listen to how our children talk and what they say and mean is a great step toward understanding their needs. They tell us they are hurting and they do not know how to deal with that hurt. Learning to respond as they need us to, rather than as we perceive they need us to would provide a significant support system to our children in pain.

Children react and respond as children, not as adults; yet we expect them to respond on our level. We do not know how to interpret their behaviors which usually say more than their words or lack thereof. As such we miss their messages and signals; they get into emotional trouble and often flounder around looking for their lost self-esteem. If they never had much self-esteem then they are at risk. Often these children are unusually sensitive, caring people with high expectations who have no way reaching them, perfectionists with emotional and sometimes physical immaturity. They may also feel isolated or rejected by their peers, while seeking acceptance.
They may often talk about suicide to almost anyone who will listen, but they are frequently ignored or not taken seriously.

A key factor for these at risk children is that they may suffer what they perceive as a significant loss, such as the divorce of their parents, a friend moving away, breakup of a boy/girl relationship, loss of a job or a pet, poor grade(s), anything they perceive as a failure, abandonment, rejection - essentially loss of control of their lives - can be the final blow. For some reason those at risk children cannot cope with loss well, and they seem to get mired in feelings of helplessness and hopelessness, and the pain is so overwhelming that the only solution seems to be to end the pain by ending their lives. Perhaps indoginous depression (whereby a chemical deficiency exists that prevents us from dealing with depression) is one cause of their inability to deal with loss and depression. Also, most adults do not believe children experience depression, at least not to any significant degree.

My suggestions include educating these allies of this silent killer so that they can listen and look more closely, not to textbook cases of teenage suicide, which only foster false security, but to the real signs and symptoms that most teenagers exhibit but which symptome are not felt altogether.

Research into what factors besides peer pressure, drugs, alcohol, abuse, pornography, and the social environment affect our children is needed. Food may be a contributing factor in the increase of teenage suicide; our foods are processed and sprayed in different ways from those of my generation.

It is my belief that there are several factors that are contributing to the wasting of lives of our country's future. We must act to reduce this, or more of us will be burying our children.

I thank you for this opportunity to make this plea.

Senator SPECTER. Mr. Scherago, would you care to add anything to that at this time?

Mr. SCHERAGO. I do not have anything.

Senator SPECTER. Mrs. Scherago, do you have other children?

Mrs. SCHERAGO. Yes.

Senator SPECTER. How many?

Mrs. SCHERAGO. We have another son, who is now 17.

Senator SPECTER. And how old was your son when he committed suicide?

Mrs. SCHERAGO. Sixteen.

Senator SPECTER. That was 4 years ago?

Mrs. SCHERAGO. Yes.

Senator SPECTER. What are the signs, if you were to give advice to other parents, who may be seeing your face, and hearing your voice, what advice would you give them as to what signs to look for about potential for suicide in their children?

Mrs. SCHERAGO. Essentially I think I would tell them to observe, rather than to listen, although listening is important, and it certainly is significant. But I think, as I said, we tend to communicate with our children as we communicate with adults, thinking that if we say no, everything is just fine, or yes, I am in trouble, then we can assume that that is exactly what is going on. It is not necessarily the case.

Senator SPECTER. Well, when you say to observe, rather than to listen, or in addition to listen, your son did talk about suicide. What did he say?

Mrs. SCHERAGO. He asked me if I had ever considered committing suicide when I was younger, and I feel like most adults, one time in their lives, yes, I did consider it, so I saw it as a very natural question.

Senator SPECTER. How long did he say that to you before he actually took his life?

Mrs. SCHERAGO. Timewise?

Senator SPECTER. Yes.

Mrs. SCHERAGO. It is hard to say. I would say anywhere between a couple of weeks, and maybe 2 months, at the most.

Senator SPECTER. So it is fairly close to the time that he actually committed suicide?

Mrs. SCHERAGO. Yes, sir.

Senator SPECTER. And how many times did he talk to you about suicide?

Mrs. SCHERAGO. Just once.

Senator SPECTER. As nearly as you can recollect, what did he say to you, and you to him, on that occasion?

Mrs. SCHERAGO. Well, when he asked me, I said sure, I have considered it. I took it kind of lightly, and he said, well, what did you think about it. And I said, well, I thought that would be nice if I did that, but then I would be kind of giving in to the reasons why I felt that way. I would be letting other people win over me, and I was not that type of personality, and I am not now, today.

So I do not know whether I triggered any further response in him, or what my response meant to him. Obviously it was not the response that he needed.

Senator SPECTER. Were you especially concerned when he talked to you about suicide?

Mrs. SCHERAGO. No. No. I thought this was a normal question for a teenager to ask.

Senator SPECTER. In retrospect, what kind of response do you think you should have given him?

Mrs. SCHERGAO. Well, my education has helped me to understand that both on a professional and personal level. I think an appropriate response would be, well, gee, are you thinking about it? What thoughts do you have?

In other words, encourage the child to talk about what is going on inside of him or her, to find out what exactly it is that triggers the question in the first place. What do you think about? What have you thought about it? Have you thought about it before? What would you like to talk about?

In other words, open up the area for discussion. The tendency is to run and hide from it. As I said, it is very frightening. Very frightening.

But when I work in a professional setting, if someone says that to me, I say what is that all about. Tell me about that, and people will share that information. They do not want to carry it around with them, not even our children.

Senator SPECTER. Mrs. Scherago, when you say that beyond listening, you should observe the child. If you were to give advice to parents about listening and observing, what would you tell other parents to try to observe?

Mrs. SCHERAGO. I would say changes in the behavior that seem to tend to isolate them, or perhaps they seem to start going in a different direction than they were headed.

Now, one of the problems with this, Senator Specter, is the fact that teenagers will do this any way, so we kind of look at them and think, now, wait a minute, if this is typical for a teenager, why is this child so much at risk? We do not know if that child is so much at risk, or not so much at risk.

So if we observe, and we become keyed into their behavior, then we are keeping track of them, more than just ignoring them. That is what I am saying.

Senator SPECTER. Well, you say observe. Look for change of attitudes, change of directions. Can you give some illustration as to what you would be looking for?

Mrs. SCHERAGO. Well, for instance, if there is a change in the performance in school, if they are having difficulties concentrating, signs of depression that are very subtle, if they are having problems concentrating, if they are spending more time alone, if they seem to be angrier than usual, if they have lost a friend recently, I see that as a real key factor for teenage suicide, a loss that they perceive, not we, but they perceive.

And in our son's situation, a best friend of his was moving out of town, now he was not moving out of the State, but he was moving a distance away, and this meant Steven would not camaraderie with him that he had enjoyed for a time before. We did not perceive that as being a critical issue for him, obviously he did.

Senator **Specter**. Beyond the parents listening and talking, do you make any recommendations about parents seeking professional help, therapy?

Mrs. **Scherago**. That is an individual basis, sir. That would be very difficult, to go across the board and say everybody should get help.

Of course, we are finding in the newspaper today that one in five people have some type of mental problem, so perhaps help might be indicated if parents feel that the situation is not necessarily out of control, but perhaps it is beyond their understanding or expertise.

Senator **Specter**. You have done some work in therapy yourself, of course?

Mrs. **Scherago**. Yes, sir.

Senator **Specter**. Are there any guidelines you could give parents in when to seek help, what signs to look for especially as a guidepost in seeking help?

Mrs. **Scherago**. If they do not seem to be able to stay on track with their child, if they really feel that there is too much of a space between them and their child, and they are uncomfortable with it, I think space is essential for teenagers, they need to know that. They have independence and the ability to do their own thing, but it has to be done within limits. And, of course, that is an individual thing, what works in one family will not necessarily work in another, so it is a very difficult thing to really zero in on. I think that I would advise parents to get their head out of the sand, pay attention to their children. If they ignore the children, it is not going to do them any good, and if they do not ignore them, it may create some anxiety initially, but at least perhaps it might save their children's lives, and it might save their family a lot of pain and anguish afterwards.

Senator **Specter**. Mrs. Scherago, you have said that one thing that you would do differently would be to have discussed the matter with your son in a different manner when he brought up the subject?

Mrs. **Scherago**. Yes.

Senator **Specter**. I am sure that you thought about this subject a lot of times as a matter of hindsight.

Can you amplify in any way what you might have done differently, which you think might have prevented his suicide?

Mrs. **Scherago**. Oh, dear. How much time do we have?

Senator **Specter**. As much as you need.

Mrs. **Scherago**. Yes.

[Pause.]

Mrs. **Scherago**. I am not quite sure I understood the question.

Senator **Specter**. Well, I think that probably the center of your experience which would be of interest to other people, would be if you were to retrace your steps.

Mrs. **Scherago**. In a broad sense?

Senator **Specter**. Well, in a broad sense, and by hindsight. We are looking at the problem in a number of dimensions, one very powerful aspect of what this hearing can do, is to tell other parents in situations like yours what to look for. We can talk about legislation, and we will, trying to provide some assistance, but probably one of the greatest aspects of these hearings is to acquaint other people with the nature of the problem, and in terms of what you can do for other people would be to use the experience that you had, the very tragic experience that you have had, to give them some insights as to what to look for.

So if you were to view this in retrospect, looking backwards, I am sure you have done this many times, conversation with each other, or as you think about the matter, if you were to look backward and find some critical point in your relationship with your son, that you might have done something differently, not that you have done anything wrong, there is no blame here, but what would you do differently with 20-20 hindsight? What would you look for, to try to have prevented your son's suicide?

Mrs. SCHERAGO. I think one of the things might be to look very seriously at these losses that children do have, and referring back to poor grades, or sudden changes, loss of a friend, something that seems insignificant and normal in all of us as we grow up, but look at them the way children look at them, and ask ourselves is this really very, very serious for him or her.

And I think—well, as I say, look at it very seriously.

Senator SPECTER. All right, that is a danger signal, the child has sustained substantial reversal, a friend just leaves, bad grades, cut from the football team, something which is very painful.

What do you do? How do you handle it? What do you say? Do you bring up the subject? Do you wait for the child to bring up the subject?

Mrs. SCHERAGO. Well, that is where I am saying that the problem may arise. They may not bring up the subject, at least not verbally, but if we start to watch them on a continuum of behavior versus how they used to act, and how they are acting 1 week later or 2 weeks later, then we have a comparison, is this child responding in unusual ways, unusual for him or her. Is there an extreme change of behavior, and by extreme, that is something that can move a quarter of an inch, or it could move 6 inches. It depends on the individual.

Senator SPECTER. So your advice would be on any sign of significant change, or some loss, try to sound out your youngster, to find out what they are thinking about, and how serious the impact is on them?

Mrs. SCHERAGO. That is easier said than done.

Senator SPECTER. Well——

Mrs. SCHERAGO. Yes, it is a very difficult thing to do.

Senator SPECTER. You have unique experience at it.

Mrs. SCHERAGO. Yes.

Senator SPECTER. How would you articulate it?

Mrs. SCHERAGO. Well, what I would do myself would be to touch base with the child, and say to him or her, gee, you know you got your report card, how did you do on it. How do you feel you did on it? Rather than to lay on the child, gee, I think you did great.

Maybe the child does not think he or she did so great. Find out from the child where they feel all of this is. How do they ride with this? And getting the poor grade, we have to be clear about this, getting a poor grade, or losing a friend does not necessarily mean that the child is suicidal. It just means that he is just one of the at risk factors.

How is that individual dealing with that? Are they dealing with that in a roller coaster kind of effect that is going on and on, or do they have the dips and the rises, the peaks and the valleys, and are they leveling off? Are they learning how to deal with the extreme behaviors, the things that are out of their control? That is what I mean by observing the behaviors.

Senator **Specter**. Well, as a generalization, it cannot do any harm to talk to your children about——

Mrs. **Scherago**. Of course not.

Senator **Specter** [continuing]. Talk about anything, and especially their problems. So maybe that is a good starting point. There is some reversal, there is nothing to be lost, and perhaps much to be gained by talking.

Mrs. **Scherago**. I agree with that.

Senator **Specter**. I am a father of two young sons myself, and I recall reading in the newspapers, from time to time, about a suicide, and I would shudder, and I would wonder what is going on in the minds of my two sons.

All right, you observe changes in their demeanor, personality, they talk about reversal.

Would you, under any circumstances—I do not suppose you would ever raise the question of suicide?

Mrs. **Scherago**. Why not?

Senator **Specter**. OK, would you——

Mrs. **Scherago**. See, that is like sex. If we do not talk about it, then the kids will not know about it, and if we do not talk about teenage suicide, then the kids will not know about it. You know that is not true.

Senator **Specter**. Well, that is a very big step, and I am very much interested in your view. I would suspect, not having had the experience, that to raise the issue of suicide would be unwise in terms of planting the idea. You had the experience, what do you think? You actually would raise the question of suicide under some circumstances?

Mrs. **Scherago**. Yes. You may not have to raise it directly as it pertains to your child, but you might raise it as it pertains to an article in a newspaper, or something on television, or in a magazine, or in a book, or someone that you may have heard about, or someone that you have heard about, that you know they have heard about it.

Gee, you know, there is an epidemic of suicides in such and such place. Are you aware of that? What do you suppose is going on with these children? Gee, that is really sad.

Senator **Specter**. Well, that is a good suggestion.

Mrs. **Scherago**. Yes. That is opening up the subject.

Senator **Specter**. You raise it indirectly in the context of something that has happened to somebody else, not something that you suggest may be on their minds?

Mrs. **Scherago**. Right, and that way you are raising the subject, and you are not pointing it at them, you are not planting any more seeds of thought than the news item itself has been planted, and you are making it a possible subject for you both to talk about in an unemotional and impersonal manner, and that is always an excellent way to deal with a subject like that.

Senator SPECTER. Mrs. Scherago, you testified that your situation did not involve either the issue of drugs or sexual abuse, and one of the areas of concern by this subcommittee is any connection between those two situations, or runaways and suicide.

Based on your experience as a therapist, in your work with other youngsters who have been involved in suicide, what is your professional opinion abut the problem of drugs as a cause of suicide?

Mrs. SCHERAGO. Well, I believe it exists, and I am sure that there are feelings of helplessness and hopelessness that our children experience in all areas of their lives, some of which we are not necessarily aware of.

Senator SPECTER. Have you seen any cases where drugs were a factor in a teenage suicide?

Mrs. SCHERAGO. Yes, I have. I have seen it more in a personal than a professional level.

Senator SPECTER. What guidance would you have for parents on the subject of drugs as a possible causative factor on teenage suicides?

Mrs. SCHERAGO. Well, certainly we do not want our children involved in drugs, but that is not always up to us to decide. I am not sure what you are asking me to say when you ask that question, so it is hard for me to answer.

Senator SPECTER. Well, if a parent knows that his child is on drugs, that would be a danger signal to the potentiality of suicide.

Mrs. SCHERAGO. Yes.

Senator SPECTER. As a therapist, realizing that your own situation did not involve this, what advice would you have for a parent whose child is on drugs, who may be concerned about the possibility of suicide?

Mrs. SCHERAGO. Well, certainly one of the things would be to check with the other resources that affect this child's life, such as the school system, maybe even friends, or if they are involved in any types of activities in or out of school, to check and see how the child's performance really is, and that might give the parents a better view of just how extensive the drug use is.

We get to the issue of up to 18 years of age, perhaps we could have these children involuntarily committed into some type of protective environment, institution, or a hospital. What do we do after they are 18, and they are adults? I could think of one family in particular who was at wits end, not knowing how to handle their 22-year-old son, and he ended up killing himself, and he was involved with drugs, and the parents were totally helpless—in any effect—to change the situation.

Senator SPECTER. How about the issue of sexual abuse? Do you think that sexual abuse is a causative factor in teenage suicide?

Mrs. SCHERAGO. I really do not know, from my own experience, both personally or professionally. But I suspect that it probably would be. Because I have put myself in kind of what I would perceive to be that role of a child, and I myself would respond on the level of saying this is not going to end my life, but that is me.

So it is an individual type of thing, but I could see where something like that would be devastating to a child. I do not think that would be the only factor, though. If it were, then I would imagine that the suicide would occur shortly after the incident of the abuse itself.

Senator **Specter**. Thank you very much, Mr. and Mrs. Scherago. Stay with us, and perhaps there will be some interaction with testimony of "Ms. Smith" and "Mrs. Smith."

We have with us Julie Smith and her mother, Patricia Smith, both of those names are not their own.

Julie, I understand that you have no objection to being photographed.

Julie Smith. No.

Senator **Specter**. I want to be sure, because if you do, we will make that announcement. We cannot control that, because this is a public hearing, and television must make its own judgments, but customarily they honor the request not to photograph, but it is all right with you?

Julie Smith. Yes.

Senator **Specter**. OK.

And, how about you, Mrs. Smith?

Mrs. **Smith**. Yes.

Senator **Specter**. It is acceptable to you, all right.

Julie and Mrs. Smith, we very much appreciate your being here.

Based on the information which has been given to me, you, Julie, have attempted suicide in the past, and having been in that situation, can shed some special light on it.

Julie, I believe you have a prepared statement, so why do we not begin with that?

STATEMENT OF JULIE SMITH

Julie Smith. OK. I have attempted suicide three times. The first attempt was in May 1981. It was merely a gesture, superficial cuts on my wrists. But luckily I was taken seriously. I was hospitalized for 6 weeks at Dominion Psychiatric Treatment Center.

After my discharge I still had self-destructive tendencies, but was allowed to continue therapy on an outpatient basis.

The following year I became anorexic, and at 70 pounds, I became a prolonged suicidal. I recovered through constant psychotherapy and familial support, a phenomenon unusual to the disease.

Tenth grade began, and I felt I could start anew. However, in December I again attempted suicide. I repeatedly slashed my wrists over the course of a week. On Sunday, I cut my arms badly for the last time and overdosed. This was the first of a series of self-destructive acts that occurred during my 3-month hospitalization.

During an immediate period after my discharge I did very well, and feeling more stable than I had in a long time. However, I began to falter, and overdosed while at camp. Since then I have been steadily progressing, and I am hoping to leave the Shelter for Suicide.

The most confusing and important issue around suicide is why. Many do not know. I believe it to be a result of a multitude of factors. The precipitating event could be anything, but in every case depression and low self-esteem loom darkly.

I believe my attempts to be focal around my childhood. I had a great many physical problems, including a kidney anomaly, which has recently become notorious as an instigator of emotional difficulty. I grew up feeling different, or flawed. I was both sculpture and statue, literally chipping away at myself. I strove to uncover the subtle yet so consequential area interlayed in my very being. My attempts were aimed at inner peace, even if that peace meant death.

I have a friend, she was hospitalized with me, but left early due to insurance. She was not only suicidal but had drug involvement, and had come from an abusive family. She could not go home, so now she is on the streets.

I have been extremely lucky in that respect. The cost of therapy has not been weighty, but I come in hopes of aiding those who are in less fortunate positions.

To those who are still struggling, I have come here to show that not only is suicide a real issue, but so is recovery, for no one in their healthy state really wants to die. The final act of suicide is a true and terrible waste.

Thank you.

Senator SPECTER. Thank you very much, Julie.

You are 16 at the present time?

JULIE SMITH. Yes.

Senator SPECTER. And you made your first suicide attempt when you were 13?

JULIE SMITH. Yes.

Senator SPECTER. Going back, although I know it is hard to do, when, if you can recall, did you first think about suicide?

JULIE SMITH. I never really thought about—well, I had always been interested in the issue, and whenever there was a special on TV I always watched it, but I never actually thought of myself in terms of suicidal, until I was actually doing it.

Senator SPECTER. You never thought about suicide until you actually tried it?

JULIE SMITH. Right Well, I mean I have seen about it, and I had an interest in it, but I never thought of myself actually doing that. I never thought I would be able to do it.

Senator SPECTER. Well, going back to what you say is the first time you had seen about it, or did you see it on television?

JULIE SMITH. Yes.

Senator SPECTER. What did you see on television?

JULIE SMITH. Mostly I saw a person telling about their experience, and then they would have the psychologist, or someone, explaining why.

Senator SPECTER. You saw somebody on television that talked to a psychologist, for example, about their committing suicide?

JULIE SMITH. Right. Attempting suicide.

Senator SPECTER. Attempting suicide, and what were your thoughts when you saw that, if you can recall?

JULIE SMITH. I was interested.

Senator SPECTER. You say interested. Did you ever think about that as something for yourself?

JULIE SMITH. No, I do not think I did. But it seems like it is an interesting subject. It is well publicized, and you just learn——

Senator SPECTER. You had a curiosity about it?

JULIE SMITH. Yes.

Senator SPECTER. Did the publicity help plant the idea in your own mind for your own attempts for suicide?

JULIE SMITH. No, I do not think so, no.

Senator SPECTER. Do you think the publicity is helpful, or harmful, in inducing people to commit suicide?

JULIE SMITH. I think it can be helpful in that it shows that there are people that you can talk to if you are depressed and you need someone to talk to. However, it is the same thing as crime and things like that, it is all glamorized, and I think that is harmful.

Senator SPECTER. Do you think suicide is glamorized by television?

JULIE SMITH. Yes.

Senator SPECTER. Why do you say that suicide is glamorized by television?

JULIE SMITH. Because when they show it on the news, or something like that, they always have all these people all bloody, and everything, running around, and I think that is not what needs to be shown.

Senator SPECTER. What do you think needs to be shown?

JULIE SMITH. I think people need to show that there is—simply that if you are feeling that way, there is help. There is somebody that you can talk to, rather than showing the actual incident itself, like on the news, or something.

Senator SPECTER. You think that the incident itself is not a good subject matter for publicity?

JULIE SMITH. No.

Senator SPECTER. And why do you think that?

JULIE SMITH. Because it is—oh, God.

Senator SPECTER. I know that is not an easy question, but it may be helpful to know your thoughts on it.

JULIE SMITH. I just think that if people see that, and they feel that they—one problem people who are suicidal have is that they want attention, and they see people in the act getting all this attention, being on the news, and I am not saying that is why they are going to do it, obviously not, but I think that is learning.

Senator SPECTER. So you think that suicide on television glamorizes, in the sense that it focuses attention to a person, that it says to a potential suicide person, this is a way—excuse me?

JULIE SMITH. This is how I can get attention.

Senator SPECTER. This is how you can get attention. So that is bad?

JULIE SMITH. Yes.

Senator SPECTER. And a desirable way to publicize is to do what?

JULIE SMITH. To have crisis centers advertised a lot. If you are feeling—so that an individual, if they are feeling depressed, can turn on the TV and have an advertisement or something, talking about a crisis center, somewhere that they can call, somewhere that they can write, anything like that, that is different, in my opinion, than having the actual incident.

Senator SPECTER. How old were you when you first saw these television programs, or first saw publicity about suicide, as best you can recollect?

JULIE SMITH. Probably around 11. Around 11.

Senator SPECTER. And how frequently did you see programs on suicide, how frequently did this subject come to your attention in some publicized way?

JULIE SMITH. Mostly on police shows, or things like that, which I really do not think are a good place for them.

Senator SPECTER. So they are just dramas, docu-dramas?

JULIE SMITH. Yes, not offering any solution.

Senator SPECTER. Now, going back to May 1981, where you testified that you slashed your wrists, as closely as you can recollect, what happened to you on that occasion? What were you thinking about? What was the compelling factor that led you to do that?

JULIE SMITH. I think I was feeling for a long while I had been isolating myself.

Senator SPECTER. Isolating yourself?

JULIE SMITH. Yes. That is one of the main things with suicides, you always isolate yourself, and when you do that it just increases your depression. I was very depressed at the time, and I think it was more of an impulse.

Senator SPECTER. You had not thought about it for a long period of time, it was an impulse?

JULIE SMITH. Right.

Senator SPECTER. And what did you do, exactly?

JULIE SMITH. I cut my wrist with a knife, but it was—it was not anything severe, it was superficial.

Senator SPECTER. Very superficial?

JULIE SMITH. Yes.

Senator SPECTER. Were you really trying to kill yourself?

JULIE SMITH. Not at that time, no.

Senator SPECTOR. You think you were not?

JULIE SMITH. No.

Senator SPECTER. Do you think you were trying to attract attention?

JULIE SMITH. Perhaps.

Senator SPECTER. Mrs. Smith, let me ask you at this juncture, what was your response to Julie's efforts to suicide, when she was 13?

STATEMENT OF PATRICIA SMITH

Mrs. SMITH. To the actual?

Senator SPECTER. Yes.

Mrs. SMITH. When I first discovered the slashed wrists at that point in time?

Senator SPECTER. Yes. Well, at the time that she made the attempt at suicide, which she has described, by attempting to cut her wrists, what was your reaction? What did you do?

Mrs. SMITH. Susan had been progressively isolating herself, as she said, we had just moved to the Washington area, and I think I can add at this point that the move was a major change, from my experience——

Senator SPECTER. Where had you moved from, a long distance?

Mrs. **Smith**. From Massachusetts. And Susan had mentioned earlier, a lot of physical ailments, and they had just put her body brace, and she was experiencing another——

Senator **Specter**. What kind of physical ailments?

Mrs. **Smith**. At this point she had developed scoliosos, and they were using a brace to prevent surgery, so we arrived with Susan in a very depressed state.

Senator **Specter**. And how long after you arrived in the Washington area did——

Mrs. **Smith**. That would have been——

Senator **Specter** [continuing]. Did Julie try suicide?

Mrs. **Smith**. Was that a year later? Yes, I think it would have been a year later, and during that period of time she just continued to get more and more isolated.

We felt very concerned about it. The interesting thing is we went to the school and talked to the school officials, and they felt that we were making something out of nothing, that they saw nothing wrong with Susan.

Senator **Specter**. You saw some signs which actually led you to go and talk to the school officials?

Mrs. **Smith**. Right. We felt that this isolation could not be good for her, and we wondered how she was doing in school.

Senator **Specter**. When you say isolation, she had no friends?

Mrs. **Smith**. She had no friends, that is right, she had refused to, after moving, to move out and meet kids in the neighborhood, the body brace created real feelings for her, so in talking to schools, the teachers, they thought that Susan was doing just fine, that at school she acted perfectly normal, and that she had friends at school. We did not agree with that, and decided to pursue the issue, by perhaps having some therapy.

We were not quite sure, certain things that you were talking about, whether this was a good idea, whether we were going to precipitate something.

Senator **Specter**. Did Julie have therapy before the suicide attempt?

Mrs. **Smith**. No. So we decided to go easy, and just saw a nurse therapist, rather than actually see a psychiatrist.

Senator **Specter**. Did she see a nurse therapist before the suicide attempt?

Mrs. **Smith**. One time. This is when we told Susan that we were very concerned about her isolation, and that we felt that it would benefit all of us, if she talked with somebody, because at this point Susan was being very angry toward us, too, and we did not feel that we could talk well with her, and so we did take her to a nurse therapist.

Senator **Specter**. You felt that you could not communicate effectively with her at that time?

Mrs. **Smith**. Right, at this point the breakdown of communication was very great.

Senator **Specter**. And you say you felt she was angry with you?

Mrs. **Smith**. Right, I think she was angry at everything and everyone. There was just hostility coming from Susan, so we did take her to the therapist, and I believe that precipitated the—her suicide attempt that night was the night that she went home and took pills.

Senator SPECTER. So you think that the first visit to the nurse therapist precipitated the suicide effort?

Mrs. SMITH. When I say precipitated, obviously Susan was at that point where she was really suicidal, and I think—this is my interpretation, was that I think there was an element of Susan being afraid that she was becoming mentally ill, or that something was happening to her, and when we confronted her with the therapist, I think that kind of scared her, and that night—well, the interesting thing was I read her diary the next day, because I was so frightened by her reaction, when we got home, the hostility had increased tenfold, and so much so that the next morning I read her diary, which I had never done before, and in it she had said that she had taken some pills, because life was not worth living kind of thing, and had gone to school, and I called the school to see if she was still all right, and they said yes, she is in class, and I called the nurse therapist back, and she recommended immediate hospitalization at Dominion Institute.

I went there, and I must admit I was so shaken by locked doors, and I could not imagine that my daughter's problem was so great that it would require this kind of hospitalization. And we insisted on a visit with the psychiatrist who runs Dominion, and he agreed to Susan trying to work on an outpatient basis, and he made a bargain with her that if she would not make any suicidal attempts over the weekend he would talk with her again on Monday, and I guess about midnight on Sunday night, Susan slashed her wrists the first time, and at that point we hospitalized her instantly. We did not wait for the morning.

Senator SPECTER. Was that the second attempted suicide, or the first?

Mrs. SMITH. Right, Susan had forgotten the pills, was the first, really, but she had not taken enough to be a serious suicide.

Senator SPECTER. She took the pills, and then you had the experience that you have described, and then she made an effort at slashing her wrists?

Mrs. SMITH. All this happened in one weekend, and then that Sunday night she slashed her wrists. But again, this is where Susan was saying they were superficial, and did not even require Band-Aids, or anything. But we admitted her in the middle of the night to Dominion.

Senator SPECTER. Susan, I will begin to call you Susan, since your mother has. Your name is not Julie, but Susan. Having used Susan, so we will use Susan. It is apparent whom we are talking about now.

What led to the second attempted suicide, Susan?

JULIE SMITH. I think it was—I have to think about that. I began to go into the same cycle that I had before.

Senator SPECTER. How long after the first suicide attempt was the second one?

JULIE SMITH. The first suicide attempt was in the 8th grade, and my second one was in the 10th grade.

Senator SPECTER. In the 10th grade? About 2 years later?

JULIE SMITH. Right.

Senator SPECTER. What was the precipitating factor of the second suicide?

JULIE SMITH. As I said, I saw myself going in the same cycle, and I felt myself slipping.

Senator SPECTER. Did you have friends at that time?

JULIE SMITH. Yes, I had friends, but——

Senator SPECTER. So you were not isolated?

JULIE SMITH. Well, I began to isolate myself again, and I felt myself going through the same cycle. I felt myself slipping, I can look back into my journals and see myself writing that.

Senator SPECTER. You kept a diary?

JULIE SMITH. Yes, pretty much.

Senator SPECTER. You are a very introspective person, you write down what you feel, and what you do?

JULIE SMITH. [Nodding.]

Senator SPECTER. How did you attempt suicide on the second occasion?

JULIE SMITH. The second time it spanned over a week. My mother went away for a week, and on the first day I cut my wrist, and each day after that I kept reopening them, and incrasing them, until the last day, when I finally cut my wrist and overdosed, the same time, and I was taken to the hospital.

Senator SPECTER. Taken to the hospital on the final effort at cutting your wrists, you inflicted severe wounds on yourself?

JULIE SMITH. Fairly bad.

Senator SPECTER. Did you come close to dying?

JULIE SMITH. No, it was more the overdose that was the problem, than the wrists.

Senator SPECTER. You took pills on the second occasion?

JULIE SMITH. Right. I did them simultaneously.

Senator SPECTER. You cut your wrist and took pills?

JULIE SMITH. Right.

Senator SPECTER. And how about the third occasion, when you attempted suicide?

JULIE SMITH. Actually, I listed as my anorexia as a suicide. It was a prolonged suicide. During my hospitalization I had several semiattempts, which I do not really go into. That was what I listed as my third attempt.

Senator SPECTER. Do you think that you are over the suicide problem at the present time, as best you can tell, Susan?

JULIE SMITH. I think I am getting there.

Senator SPECTER. You think you are?

JULIE SMITH. Yes.

Senator SPECTER. If you had to give advice to other teenage girls in the United States about the problem of suicide, how to avoid it, how to approach it, what advice would you give?

JULIE SMITH. I think they need to be able to trust people, to talk, to confide in people about their feelings. I think they need therapy. Therapy is definitely a major thing, and familial support is important.

Senator SPECTER. If you were to give advice to other teenage girls who were in the same situation that you were, what is the critical point, would you say, at what point is really the most dangerous that they have to seek some sort of outside help?

JULIE SMITH. I think any time you are feeling suicidal you should seek outside help. The problem with suicide is everyone becomes introverted, and they do not rely on anybody else to help them with their problems, and when you keep things inside, at least in my case, they become very fast and inculpable, and when you speak about them they sort of shrink inside, and you have to deal with them.

Senator SPECTER. So you would say the critical factor is when a teenage woman is thinking about suicide, to tell somebody about it, share her thoughts and feelings?

JULIE SMITH. Right.

Senator SPECTER. Susan, you are in a therapy group, as I understand it, with other youngsters?

JULIE SMITH. I was, when I was in the hospital.

Senator SPECTER. You were when you were in the hospital?

JULIE SMITH. Yes.

Senator SPECTER. What did you learn from them, if anything, that would be helpful to other teenagers, to understand their own problems on suicide?

JULIE SMITH. A therapy group helps develop trust in other people, it also shows you that your problems are not—that some other people may have the same feelings that you are having, may have the same perspective on things, and you do not feel quite so alone in your depression.

Senator SPECTER. So if you know that other people are experiencing similar problems, it is of assistance to you?

JULIE SMITH. It helps, yes.

Senator SPECTER. Well, thank you very much, Susan.

If you had one last piece of advice to give to teenagers who may be seeing your face and hearing your voice, about how to prevent suicide for themselves, what would you say?

JULIE SMITH. I would say that they really—it really is not worth it, that things will get better, no matter how bad things may seem, they will get better, and they need to hold on, and they can, it is easier to do that with the help of other people, with the help of professionals, but just to hold on.

Senator SPECTER. And, Mrs. Smith, based upon the experience that you had with your daughter, who has attempted suicide, what advice would you give to parents, to try to prevent suicide?

Mrs. SMITH. Well, I think that today in our society that parents sometimes are a little bit afraid of their kids, and a little bit afraid to really step in and appear more of an authority figure, that there is a tendency to kind of want kids to experience things, and you sort of step back and play a less active role, kind of a supportive role, and that is good, but I think that a lot of children are asking for more involvement in their lives, more actually stepping in, and——

Senator SPECTER. More parental involvement in the lives of the children?

Mrs. SMITH. Right, and more control over their lives, that in fact——

Senator SPECTER. More control that the children would like to have the parents exert more control over the children?

Mrs. **Smith**. That is right. In fact, they do not really resent having parents step in, and I think one of the things I have learned from this experience is to step in more, and to take things into your hands, as I said, confront them, you know, are you feeling suicidal, in our case now, we have a very open dialog about it, but I can see in the case of other families who have not experienced something like we have, where it would be beneficial to confront children with specific problems, and not be afraid to do that, and really, for example, Susan talked to me a long time before, she may not even remember it, before her first suicide attempt, but she always talked about it as other children, and I was lulled in that.

Senator **Specter**. She had talked to you about suicide?

Mrs. **Smith**. About suicide, but it was sort of in, my friend is thinking of doing this kind of a thing, and my friend has a thing who has done this sort of thing.

Senator **Specter**. When Susan talked to you about suicide, as you described it, what did you say to her?

Mrs. **Smith**. Well, I would be very concerned and would talk about it, but it was always about a friend, and would sort of imply that perhaps, you know, does the teacher know, does the parent know that the child is experiencing these kinds of feelings, and looking back on it, I had no idea that what she was really telling me was that this is what she was feeling, and we were having these discussions about, you know, someone else, some nonexistent person, and so I am sure, I do not recall how I responded in terms of everything I said, only merely I hope she gets help. That kind of thing, rather than saying, hey, are you trying to tell me something.

You know, and perhaps we should talk about your feelings about this subject. So I guess if I had to give one piece of advice, as you said listen, observe, but get involved, and not be afraid.

I mean, sometimes you may make mistakes and step on their toes, and they are going to get angry and say, hey, you are too involved in my life, but I think overall they appreciate that, and they feel that there is some control here, that they may not feel otherwise.

Senator **Specter**. Susan, one final question.

From your group therapy, I know this does not apply to your own case, but from the group that you worked with, do you have any sense as to whether sexual abuse or drugs were a cause of suicide for teenagers?

Julie Smith. A great many of the people in the hospital have had experience with drugs or sexual abuse.

Senator **Specter**. A great many of the youngsters you associated with had backgrounds in drugs as a causative factor leading them to suicide, or attempted suicide?

Julie Smith. Well, I would not say that it is the cause of suicide, but——

Senator **Specter**. A contributing factor?

Julie Smith. But it only served to really shake your self image, self esteem, and that is going to lead to suicidal problems.

Senator **Specter**. How about the question of sexual abuse? Have you seen from your experience with others who have attempted suicide, that that is a factor?

Julie Smith. I think so, yes.

Senator SPECTER. Thank you very much, Mr. and Mrs. Scherago, and thank you very much, Mrs. Smith and Susan. I appreciate your being here.

I would like now to call District Attorney Ownby and Dr. Alan Berman and Ms. Myra Herbert.

District Attorney Ownby, we would like to begin with your testimony and your experience.

I understand that you are the district attorney for Collin County, TX, the county where Plano is located, and have had experience with some nine suicide victims in Plano, your office has been involved in the investigation in that matter.

We appreciate your coming, and we will begin with your statement.

STATEMENTS OF A PANEL CONSISTING OF H. OWNBY, CRIMINAL DISTRICT ATTORNEY, COLLIN COUNTY COURTHOUSE, McKINNEY, TX; DR. ALAN L. BERMAN, PH.D., PROFESSOR OF PSYCHOLOGY, THE AMERICAN UNIVERSITY, AND PRESIDENT OF THE AMERICAN ASSOCIATION OF SUICIDOLOGY, ON BEHALF OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION, WASHINGTON, DC; AND MYRA R. HERBERT, M.S.W., COORDINATOR, SCHOOL SOCIAL WORK SERVICES, FAIRFAX COUNTY PUBLIC SCHOOLS, FAIRFAX, VA

Mr. OWNBY. Thank you, Senator Specter, and we appreciate your taking the time, and your committee working on this subject, because this is obviously of a great deal of concern to us.

Unfortunately, I must report to you that at this time we have now experienced 11 deaths by suicide, of individuals aged 20 or under, in the last 2 years.

I would like to start by telling you a little bit about Collin County. It is about 1,000 square miles, immediately north of the city of Dallas, and the major city is Plano, with a little over 100,000 people.

Senator SPECTER. How far north of Dallas is it?

Mr. OWNBY. Well, it is the county immediately to the north. Plano sits approximately 20 miles north of downtown Dallas. The city of Dallas now considers——

Senator SPECTER. Practically a suburb, then?

Mr. OWNBY. It is a suburb. There is no break in the residential area. Most of the people who live in our community work in the Dallas area, they commute in. It is a very mobile society, upper middle class, very expensive homes, most of them are $150,000 or more. Median income in our community, in Plano, is about 50 percent above the national average. An awful lot of people move in, and then move out, because they belong to major corporations.

As I said, we have experienced about 11 suicides, people aged 20 or under, in the last 2 years. Specifically in the last 20 months. We have also experienced a great number of attempts.

Now, unfortunately, because of the short time that I had been noticed to get here, I did not get perfect statistics. In that same time period, Plano General Hospital, which is the primary health care unit in Plano, has reported to us about 95 suicide attempts.

That is the whole age spectrum. I do not know how many of those break out to be teenage.

I do know that in our mental health court, which has just been in existence in the last year and a half, since January 1983, we have had 13 involved, in 1983, and 11 in 1984, attempters, who have been committed to some kind of mental health facility.

According to statistics modeling, our county, by population, should experience approximately three per year. We are obviously well over that.

Senator SPECTER. Three suicide attempts?

Mr. OWNBY. Three suicide attempts in the ages 20 and under—no, three suicides.

Senator SPECTER. Three suicides?

Mr. OWNBY. How many statistically we should model out. Attempts, I cannot say.

Senator SPECTER. Is the figure 95 suicide attempts high, as you sense it?

Mr. OWNBY. It appears to compare favorably with prior years. But again, that is 95 throughout the entire spectrum.

Senator SPECTER. What is it about Plano, TX, which leads people to suicide, or attempted suicide?

Mr. OWNBY. I do not know. I am not going to sit here and try to draw conclusions that I cannot back up. I have looked at a lot of the factors that we knew about, or we thought about, or that your committee has suggested to me. I do not find yet that single strain that will tell us what the answer is.

We looked at juvenile system involvement. Have they been in trouble before. We only found one individual who had any prior contact with the juvenile justice system.

We looked to sexual abuse. It is very difficult. The primary witness in a sexual abuse case is the one who is now deceased. So we do not really know. We do know that we see a low incidence of sexual abuse reported by those people who are suicide attempters, they are saved and put into the mental health.

Senator SPECTER. Have any of the 11 suicides been a person who had reported sexual abuse?

Mr. OWNBY. None.

And in substance abuse we have got some evidence that every one of these individuals began some involvement with either alcohol or drugs, in some minor scale, but out of the 11, I have got 7 autopsies available, of those, only 1 shows any alcohol or drug during a screening at the autopsy, and that one was substantial alcohol intoxication, it was 0.20, which I am sure you know what that means, and he also had a substantial amount of Diazamine in himself.

We checked into status crimes, that is what are referred to in Texas as juvenile delinquency, and that sort of thing. Runaways, we found none, no reports. And the policing agencies on the individuals who did in fact commit suicide. We tried to determine if there was any more graphic involvement, and we could not find any evidence of that.

I have not been able to look into the behavioral or family problems involved with these. I know a little bit, by rumor and by conjecture, and by some personal involvement with a few of the people, but not enough that I could draw any kind of conclusions for you.

I will tell you, Mr. Gorman, who is with the Centers for Disease Control, has been in Plano last March doing statistical gathering, he is coming back this month to do some indepth interviews with families and friends of suicide victims, and he is going to be dealing with that kind of approach, what kind of traits are there in the families that we can look at.

One thing that I can tell you by looking at the suicide attempts that we dealt with in our mental health system, divorce is a factor, and adoption seems to be a factor.

They asked me to see what kind of police or other investigations were accomplishing. The police only investigate so far as to determine the cause of death, that it was suicide.

Senator SPECTER. How do you, as district attorney, get involved in a suicide? A suicide attempt is not a crime, or is it a crime in Texas?

Mr. OWNBY. No, it is not a crime in Texas. The only way that I get involved at this point is because the autopsies are reported to me, and, of course, the deaths are reported to me, the police report comes to my desk.

Senator SPECTER. I know that a lot goes to the district attorney that has no place else to go, but technically, there is no crime involved?

Mr. OWNBY. No.

Senator SPECTER. Mr. Ownby, did these 11 suicide victims know each other? Was there a strain of commonality? Did they know each other?

Mr. OWNBY. Apparently a couple of them may have had some contact. There were none of them——

Senator SPECTER. May have had. There is no evidence that any of the others?

Mr. OWNBY. Not that I can testify to. When Mr. Gorman comes in and does his study of the family we may find a greater cross relationship was there.

Many of them attended separate schools, and had no reason to be cross contacting.

Senator SPECTER. Do you have any sense that there was a chain reaction that after a number of suicides that occurred in your small community, that it gave the idea to others?

Mr. OWNBY. That is a definite possibility. I was asked to determine what is the role of the press, and I talked to the reporters of all the major newspapers.

The first suicide that occurred, there was a fairly decent reason for that one to occur.

Senator SPECTER. What was the reason?

Mr. OWNBY. OK. There was a drag race involving three young men. Two boys driving the cars, one was the flagman. One of the boys lost control of the car and struck and killed the flagman. The other boy who was in the drag race but not involved with the striking was a good friend of the flagman, and it was several days later that he decided to take his life because he felt guilty, he felt at fault. They tended to domino after that. That one incident was reported widely, and it was reported on the front page of the local papers.

The newspapers assured me that after that they had tried to play it down, until we had a Romeo and Juliet suicide several months later. That one again was on the front page, and after that one we had several quick suicides.

Senator **Specter**. A double suicide?

Mr. **Ownby**. Yes, sir.

Senator **Specter**. And what were the factors there?

Mr. **Ownby**. They apparently wanted to be together in some sign of marital relationship, and their parents were denying them. They were saying they were too young.

Senator **Specter**. How old were they?

Mr. **Ownby**. They were 17.

Senator **Specter**. How about television coverage?

Mr. **Ownby**. Television coverage was rapid and pervasive. There is a school three blocks from my home, and a young man there committed suicide last year. When he did, the minicams were all over the place, interviewing every student who had said they had seen or talked to this kid.

It is strange to note that recently a television anchor woman in our city of Dallas committed suicide, and had received very scant coverage.

Senator **Specter**. How much coverage do suicides get generally in the Dallas area?

Mr. **Ownby**. The Dallas area, very little.

Senator **Specter**. Big city?

Mr. **Ownby**. Big city.

Senator **Specter**. Not an uncommon occurrence?

Mr. **Ownby**. No, about a million people.

Senator **Specter**. But 11 are?

Mr. **Ownby**. Plano is. There is some relationship between the first suicide and the arrival on the scene of some reporters from Newsweek to do a story about Plano. They were coming anyway, and they were there when it happened. I think that may have something to do with the extreme breadth of news coverage.

Senator **Specter**. What is your sense as to why the Newsweek story had anything to do with the suicide?

Mr. **Ownby**. I do not know that they had anything to do with the suicide. I do know that that had something to do with the amount of coverage.

Senator **Specter**. I see. So you are talking about the Newsweek story having a relationship to the coverage, as opposed to the incidents?

Mr. **Ownby**. Right. Newsweek is normally not in Plano.

[The prepared statement of Mr. Ownby follows:]

PREPARED STATEMENT OF H. OWNBY

Thank you for this opportunity to address the Subcommittee on Juvenile Justice. The tragedy of juvenile (or teenage) suicide is foremost in the mind of our community at this time, and we are comforted to know that not only this body, but other organizations with expertise in this subject have come forward to help us solve this problem.

In the last two centuries our nation has worked hard to remove hunger and disease as the leading causes of loss of young lives, and our community believes that suicide is one more affliction that can be removed as a threat to our children. The primary weapons in our battle are dedication, open minds, courage to face the truth, and love.

In response to the committee's request I have contacted various agencies, service providers, and leaders of our community for their information, contributions, and insights. My staff and I have also conducted independent research. Time, always the enemy of decision makers, was regrettably short, but the information supplied should be as accurate and complete as is humanly possible.

COMMUNITY BACKGROUND

Collin County is a predominately rural county, population approximately 180,000, 900 square miles in size, located immediately to the north of Dallas. The county seat is McKinney, approximately 20,000 population. The largest city is Plano, population approximately 120,000, with a median household income in excess of $40,000, which was a small farming community of less than 5000 population until the late 1960's. Residential growth in Dallas has caused Plano to develop as a true metropolitan suburb. Although predominately a "bedroom community", internal business and industrial growth are currently changing Plano and Collin County into a more self-contained community. Population estimates range up to one million by the end of the century. Each city within the county maintains an independent government, including police and school systems.

SUICIDES:

Collin County, Texas, has experienced a significant change in the pattern of juvenile suicides (age 20 and under) during the last two years. A ten year calendar showing ages and occurence is attached. It is evident that juvenile suicide was rare before 1983. Population growth, by itself, will not account for this sudden change, since the most significant changes in population occurred in the 1970's.

A full and complete understanding of why these young people took their lives is not yet available. It may never be fully understood. However, Ms. Carole Steele, Executive Director of the Plano Crisis Center undertook a detailed analysis which she reported to the American Association of Suicidology's 1984 Conference. A copy of her report is attached.

INVOLVEMENT IN JUSTICE SYSTEM:

Police and Courts:

Only one individual had any reported contact with policing authorities. The record showed a felony offense two years prior to death (refused by District Attorney for insufficient evidence) and a misdemeanor one year prior to death.

SEXUAL ABUSE: None reported.

SUBSTANCE ABUSE: Almost all of the subjects had begun involvement with drugs or alcohol. A significant number were involved with either drugs or alcohol, or both, at the time of death.

RUNNING AWAY FROM HOME: No information available.

EXPOSURE TO PORNOGRAPHY: No information available.

BEHAVIORAL OR FAMILY PROBLEMS: No official investigation was made of these areas. Through unofficial investigation, Ms. Steele details in her report several factor conclusions which relate to these areas.

INVESTIGATION:

Police: Local policing authorities only investigate suicides from the standpoint of determining criminal activity and securing evidence to determine cause of death.

Justice of the Peace: By Texas law, deaths occurring outside of medical supervision are referred to a Justice of the Peace for determination of cause of death. The JP can, and often does, hold an inquest and seek more information than just the medical cause, but this information is not uniform in its reporting.

COMMUNITY RESPONSE - PREVENTION:

Plano and Collin County have made significant moves in the last two (2) years to combat this problem. In addition to Ms. Steele's report, I have attached detailed information provided by Dr. Glenn Weimer, psychologist and Director of the Plano Crisis Center, and Mr. Mike Cavender, Administrator of the Plano Involvement Program with the Plano School District.

Here is an overview of the systems available now:

1. Plano Crisis Center: 24 hour hot line provides crisis intervention and referral by professionally trained volunteers.

2. Collin County Mental Health Department: Trained Deputy Sheriffs can respond county wide to both law enforcement agency and citizen reported problems. System can provide intervention, temporary committment for safety, and immediate psychiatric involvement.

3. Neighborhood Youth Services: A diversion project of the Plano Police Department, juvenile offenders can be placed in a counseling situation, rather than incarceration and formal court action, if warranted.

4. Plano School District: Numerous projects aimed at involving the parents and the community in problems of children, before the problem reaches the police stage. This includes a District wide Parent Involvement Program (too many children had no real communication with their parents; many parents refused to believe their child was involved with drugs of alcohol), and Students Working All Together (SWAT) and Students Thinking Of Peers (STOP) which involve students taking the initiative to

defeat loneliness (being left out of the group) and peer pressure involving drug, alcohol, or other improper activites. Individual information sharing, or clearinghouse, activities have started in several schools in the past year. The details are best left to the attached materials.

ROLE OF THE PRESS:

The Plano Daily Star Courier provides primary coverage of events in Plano, although the two major Dallas papers do cover Plano activities and have wide circulation in Plano.

Because of the nature of the first suicide, it was covered on page one of the Plano paper. Likewise, the double suicide received page one treatment. All others were reported on page three as a four or five paragraph "police report" only.

In fairness I asked reporters from several papers for their comments on this subject. Some felt it was only a question of the public's right to know; but one reporter pointed out that, while the news reports may trigger further suicide activity, they may also warn parents of suicidal children of the danger signs and may save lives.

CONCLUSION

There are no answers, yet. There are many people working very hard to fight an enemy we do not understand. The Center for Disease Control has visited Collin County to gather information, and will return later this year. There are children, and adults, solving problems that would possibly have gone unsolved before. Local agencies and authorities are communicating better than before on juvenile matters.

The only conclusion I have drawn from my very short research of the problem is the need for sharing of information. The exchange of background information on children by the schools, police, medical, and religious community is vital to the interception of problem children before they "solve" their problem. And the sharing of hard-won answers to common juvenile problems is vital to intercepting situations before they become problems for a child. The clearinghouse approach may be the next logical step for our community, and to that end, a number of people are currently working.

The only other conclusion I have reached is one I have held for many years. Systems do not work. People work. Systems help.

OCCURRENCE OF JUVENILE (TEENAGE) SUICIDE IN COLLIN COUNTY, TEXAS 1973-1984

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
1973									#1-17			
1974												
1975												
1976												
1977		#2-14										
1978												
1979												
1980										#3-18		
1981												
1982												
1983		#4-16	#5-18	#6-14				#7-17 #8-17 #9-18			#10-20	
1984		#11-14		#12-20	#13-18			#14-20				

Senator **Specter**. Well, we shall be interested to see what the followup studies show, Mr. District Attorney. It is a very unique situation, and I think there is something to be learned from that.

Let us turn to Dr. Alan Berman now.

Dr. Berman, as I understand it, you are the president of the American Association of Suicidology?

Dr. **Berman**. That is correct.

Senator **Specter**. Would you begin by telling us a little bit about the Association of Suicidology, when it was formed, the membership content?

STATEMENT OF ALAN L. BERMAN

Dr. **Berman**. The American Association of Suicidology was founded in 1967 by Dr. Edwin Shneidman in Los Angeles, who, when he started working with suicidal individuals in Los Angeles County, found that there was painfully little research available to study and understand suicidal phenomena.

Since then we have grown slowly. We have about 700 members, mostly mental health professionals, several surviving parents, and lay people interested in the subject. Primarily, our interest is in understanding the problem of suicide, and hopefully proposing models to deal with it.

Senator **Specter**. What is your own educational background—you are a Ph.D. in clinical psychology?

Dr. **Berman**. Yes.

Senator **Specter**. And how long have you been practicing psychology?

Dr. **Berman**. Fifteen years.

Senator **Specter**. And you are a professor in the Department of Psychology at American University?

Dr. **Berman**. That is correct.

Senator **Specter**. Well, we thank you for being here, and look forward to your testimony.

Dr. **Berman**. Thank you. If I can briefly summarize my written comments.

First, I do want to thank you for inviting me here to speak. I am here to represent the American Psychological Association as well as the American Association of Suicidology, and, perhaps, if I can extend that, to represent more than 5,000 suicidal adolescents from last year; that is, 5,000 adolescents who cannot be here to testify, because they are tragically and prematurely dead.

Senator **Specter**. 5,000 adolescents last year?

Dr. **Berman**. Over 5,000 last year, and that is what we know of. Obviously, that underestimates those deaths that are otherwise certified, or those whose suicides may have been denied awareness to a medical examiner or coroner.

In recent years, Senator, the rate of suicide deaths of teenagers have shown a marked and dramatic increase, roughly an increase of threefold, in the last 20 to 25 years.

Concurrently, the United States has shown dramatic increases in the rate of divorce, and the numbers of children involved in those divorces; and in the rate of illegitimate births to adolescent girls, rate of juvenile court appearances for adolescents. As well, rates of other violent deaths, for example homicide rates, have gone up dramatically.

While these are correlated, in no way are they explanatory. Suicide is an intensely personal event. It is complex, and it is multidetermined. For some it is an impulsive behavior, for others it is a career. There is no one motive, there is no one type, there is no one suicide that I can tell you about.

Perhaps I can assume all motives under two primary themes. One is that of influencing others, to communicate a statement that otherwise cannot be expressed. Second, to escape some intolerable situation, some conflict; some attempt to get out when other ways cannot be accomplished.

The great majority of adolescent suicides that we know of apparently do not, or did not, want to die; but, perhaps, did not know of any other ways to deal with their problems. These suicidal individuals appear to share a common pathway with other forms of escape and indirect communication: runaways, drug abusers, alcohol users, and delinquents. I guess they share an underlay of despair, of rage, of helplessness, and of depression.

To date our research does indicate that there are a number of factors that we can point to that show an adolescent at risk for suicide. There is painfully little research. We are desperate in terms of asking for funds so we can upgrade what we know. But we do know some things, and one of the values of this meeting today is that we can perhaps isolate and publicize what we have learned over the years.

Clearly, adolescents give messages on their way toward death. We know that roughly 80 percent will communicate in one form or another that suicide is on their mind, and that it is a possibility.

Studies of suicidal adolescents, both attempters and completers, have found typically that—again, this is a generalization—that there is a high level of conflict in the family, there are oftentimes threats of, and actual, separation and divorce. Parents have been shown to be more depressed than parents of nonsuicidal children.

Studies have found higher rates of alcoholism, higher rates of drug abuse among the parents, and, as well, more suicidal models in the parenting system that may, perhaps, give the potentially suicidal adolescent some permission for using this behavior as a way of solving problems.

Children in families such as these tend to feel expendable, if not sometimes responsible for problems going on in the family. The parents may or may not be in a position to notice. These adolescents do show behavioral changes at school; they also show behavioral changes with peers.

We have been able to note increased rates of depression, that is, diagnosable, clinical depression; signs of withdrawal, as well as signs of greater aggressivity and hostility, more disruptive behavior. They do appear to be more sensitive, more easily hurt, and less able to reach out to support systems that may or may not be available.

There are things that can be done. The clues are given clearly. If we can assess better, if we notice more, perhaps we can channel them into helpful systems. We do know that those adolescents that make it into individual therapy, group therapy, or to the family therapy, have been helped. They can be taught; they can be given training in problem-solving skills.

We do know of school-based programs that have been tried, that seem to be successful in teaching adolescents not only about their own depression, but about how to respond to peers, in teaching teachers how to notice, and again, funnel children into helpful recourses.

As you mentioned in your opening statement, there are two States that are currently providing moneys to support demonstration projects to develop preventative programs in the schools. At present, there basically is no Federal money to support either research or programmatic initiatives. That is one of the reasons I would like something to come of this, and I hope that we can get to that.

Thank you.

[The prepared statement of Dr. Berman follows:]

PREPARED STATEMENT OF ALAN L. BERMAN

Mr. Chairman and Members of the Subcommittee on Juvenile Justice, it is indeed an honor to be invited here today to testify on behalf of the American Psychological Association on the subject of teenage suicide. I am pleased that the Subcommittee has directed its attention to this serious national problem and would like to take this opportunity to commend your outstanding leadership in efforts to safeguard the welfare of our nation's youth.

I am Dr. Alan Berman, Professor of Psychology at The American University and President of the American Association of Suicidology. My professional expertise in the area of teenage suicide is derived from counseling suicidal adolescents and their families, conducting research projects and workshops, and teaching university courses on the subject.

In my testimony, I will present the psychological knowledge regarding three major areas of concern: (1) the characteristics of the at-risk adolescent, including contacts with the juvenile justice system; (2) the clustering phenomenon wherein one suicide triggers a rash of suicides in a closed community as was recently reported in Westchester County, New York and Plano, Texas; and (3) ways to help teenagers through the crises of adolescence and thereby deter them from acts of self destruction.

Now more than ever before, families, communities and the nation as a whole are facing the tragedy of teenage suicide and asking "why?" The acceleration in empirical research in the area of teenage suicide in the last several years follows closely and parallels reports of dramatic increases in the incidence of these deaths (Berman & Tanney, 1984). Unfortunately, there is a lag of about three years before final mortality figures are published by the government and a further lag of several years before any one empirical study can be organized, carried out, and published. Therefore, to have a body of well-conducted research which meaningfully addresses both the questions of "Why?" and "What can be done?" demands inordinate patience among those eager for answers.

It is not that the problem of adolescent suicide is new. It is that the significance of the problem has only recently emerged. Consider for a moment the following startling facts about teenage suicide:

o One out of every five suicides in 1980 involved a 15- to 24-year-old male.

o Between 1960 and 1980, the suicide rate for the 15-to 24-year-old age group in the United States more than doubled from 5.2 to 12.3 per 100,000. This 136 percent increase made suicide the third leading cause of death in this age/group.

o In absolute numbers, over 5,200 teenagers committed suicide in 1980; accounting for 11 percent of all deaths among 15-to 24-year-olds in our country.

o With the exception of the adolescent/young adult (15-24) segment of the population, overall mortality rates have decreased for every age group (Healthy People, 1979). These disturbing statistics can be explained by the sharp rise in violent (suicide and homicide) deaths among the young (Seiden and Freitas, 1980; Holinger, 1979).

o Firearms and explosives accounted for 62 percent of all suicides among 15- to 24-year-olds in 1980. The increase in the use of guns accounts for almost all the increase noted in youthful suicides (Boyd, 1983), It is interesting to note that fully 85% of those using firearms are male and that states with stricter handgun control laws have lower rates of suicide by firearm (Lester & Murrell, 1982).

o As with males, the majority of young females use firearms to kill themselves (52% of females versus 64% males); yet they are more likely than males to ingest drugs and poisons (20% of females versus 6% of males). This sex-specific choice of method has long been thought to be one of the main reasons why men are overrepresented as completed suicides and why women are overrepresented as non-fatal attempters.

o Racial differences are also evident in that more than one in four black suicides (26%) is aged 15-24. While the suicide rate for minorities is significantly lower than that for the white majority, the greatest increase in rates has been noted for young black males who, in addition, have had traditionally high rates of homicides as well.

The "At Risk" Adolescent

While suicide may best be viewed as an intensely personal act, a great variety of social forces impinge on any individual's sense of self, needs, resources, and behavior. Berman and Cohen-Sandler (1982) have outlined a sample of indicators of societal change affecting the adolescent population. Profound increases in the number of children of divorced families, births to unmarried adolescent women, drug use, running away from home, and juvenile arrests are but a few of the signs pointing to potential explanatory factors.

A recent study of runaway and homeless youth seeking refuge in emergency shelters in New York City reported significant psychiatric problems among this population, including depression and suicidal behavior, antisocial behavior, or a combination of these (Shaffer & Caton, 1984). Of the 118 youths interviewed, at least one-third of the girls and one-sixth of the boys had at some time attempted suicide. A related study of 150 delinquent adolescents at a coeducational youth correctional facility in Washington State found that 30 of the 13- to 15-year-olds interviewed (or 20% of the sample) had previously attempted suicide (Miller, Chiles & Barnes, 1982). The average age at which the first suicide attempt occurred was around 13 years, with the earliest attempt at age 7. The group averaged about 3 attempts per youth, with a range of 1 to 5 attempts. Furthermore, when youth such as runaways and delinquents are inappropriately detained in adult jails and lockups, they may attempt suicide while in the facility. As documented by a 1981 University of Illinois report prepared for the U.S. Department of Justice, the suicide rate of juveniles in adult jails is eight times greater than that of juveniles in juvenile detention centers and five times greater than that of youth in the general population (U.S. Department of Justice, 1981).

Males, both white and black, complete suicide at rates better than four times those for females. In contrast, females outnumber males by about the same ratio when available data on attempted suicide are examined. The significance of these data lies in the fact that attempters and completers, as groups, appear quite different. Although one may be defined as an attempted suicide in a number of ways (e.g., intending to complete suicide but being rescued, intervened with, or failing to complete versus not intending to die but rather to communicate an otherwise unaccepted message), the typical completed suicide in adolescence is a male using a gun and the typical adolescent attempter is a female ingesting pills.

Since the attempted suicide remains alive and, consequently, is available for observation and study, what we have learned about the suicidal adolescent has come primarily from our study of young women and is retrospective in nature. Nevertheless, much can be learned from the suicide attempter. And, it is important to note that there is overlap between those groups. Once a youth is despairing enough to jeopardize his or her life even without intent to die, the likelihood of future and perhaps more lethal suicidal behavior increases.

The majority of research on suicidal adolescents has focused on family and parental dynamics. Adolescents, by definition, are caught between childhood and adulthood. The often intense and conflictual task of separating from the world of parents and family can be all the more difficult when family dynamics interfere with the child's move toward self-sufficiency. Parents of suicidal adolescents have been characterized by more overt conflict and threats of separation and divorce, often culminating in the loss of a parent for the child prior to his or her 12th year (Miller et al., 1982; Corder, Shorr, & Corder, 1974; Stanley & Barter, 1970). Various psychological problems ranging from depression, alcohol, and drug abuse (Tishler & McKenry, 1982) to current and chronic suicidal behavior (Garfinkel et al., 1982; McKenry, Tishler, & Kelly, 1982) have also been found to characterize parents of suicidal adolescents. Suicidal adolescents report receiving little affection (Korella, 1972). They hold negative views of their parents and see themselves as different from their parents (McKenry et al., 1982). When families of a suicidal adolescent have been observed interacting on a task, communications to the suicidal adolescent have been found to be limited and often punitive (Abraham, 1978).

It is understandable, then, that suicidal adolescents describe time spent in their family as unenjoyable (McKenry et al., 1982) and have been found to have deficient problem-solving skills (Hynes, 1976; Levenson & Neuringer, 1971). Without adequate attention to fulfilling the adolescent's need for nurturance and skill training-- those ingredients essential for psychological growth--the adolescent at risk for suicide is one who lacks the resources needed to deal with the crises of growing up. The suicidal adolescent feels expendable, yet is unable to separate and leave. Instead, he or she develops poor reality testing and becomes more hopeless and depressed (Tishler & McKenry, 1982; Topol & Reznikoff, 1982). Suicidal behavior, then, may serve as a form of communication, a cry for help to whomever might care, or a way to escape a seemingly insurmountable problem.

Other cues of despair and poor problem-solving skills may be evident in the adolescent's behavior. Drug and alcohol use and aggressive behavior have been found to be more prevalent in histories of suicidal (vs. non-suicidal) adolescents (Garfinkel et al., 1982; Korella, 1972).

In addition to focusing on the family, psychological studies have also examined the suicidal adolescent's behavior at school and relationships with peers. With respect to school behavior, suicidal adolescents are more likely to emotionally withdraw from school (Gibson, 1982; Corder et al., 1974; Korella, 1972). School problems have been found (Sarles, Reynolds, & Heald, 1979), and underachievement and poor school performance have characterized this group's pre-suicidal behavior (Garfinkel et al., 1982; Korella, 1972). Yet it should be noted that while the academic problems are typical of suicidal adolescents, they may describe the much larger class of depressed adolescents as well; unfortunately, no study of suicidal adolescents has, as yet, discriminated them from depressed, non-suicidal adolescents (Berman & Carroll, 1984).

The academically capable, but truly depressed and potentially suicidal, adolescent is rarely pleased with academic performance--making the error of reasoning that a grade of "B" is the equivalent of an "F". When such perceived failures occur, they have the potential of heightening the sense of despair and hopelessness already felt. Suicidal adolescents have been found to feel more pressure to do well in school (McKenry et al., 1982). Perceived failures, thus, may lead the adolescent to fear an even further loss of recognition from those family members who demand academic performance.

It is common that adolescents will at one time or another have suicidal fantasies (Cantor, 1976). It is also true that adolescents focus more on the present than the future. When an adolescent experiences stress, then, a constricted view of future possibilities and a momentary fix on present escapes may hold sway. Impulsivity and poor alternative problem-solving may make suicidal fantasies turn to suicidal behaviors. A positive and healthy interaction with peers may be sufficient antidote to this destructive process.

Active peer involvement (e.g., dating and shared activities) and close relationships with parents have been found to be inversely related to depressive mood in adolescence (Kandel & Davies, 1982). In contrast, suicidal adolescents have been found to have more frequent and serious problems with peers, to be more interpersonally sensitive, and to be less likely to have a close confidant (McKenry et al., 1982; Tishler & McKenry, 1982).

The Suicide Clustering Phenomenon

Peers have one other significant effect on the potentially suicidal adolescent: contagion. Adolescents are highly suggestible, eager to imitate others in their quest to establish a suitable identity. Suicidal adolescents are highly vulnerable to influence as they lack positive role models and are low in self-esteem. Thus, when a suicide occurs and receives attention and response in a community (e.g., a school), it is not uncommon to find subsequent suicidal behaviors, often a "rash" or epidemic of followers. It has been proposed that the first suicidal behavior serves as a model or permission giver to others who had been contemplating such an action (Berman & Yufit, 1983). The phenomenon of contagion is most important for us to address through our interventions and prevention efforts at the school and community level. The Centers for Disease Control of the U.S. Public Health Service are currently conducting a major study to explore this puzzling and tragic phenomenon.

Sample Cases: Types and Motives

The decision to end one's life can never be simple. Suicide is a complex, multi-determined behavior that is acted out either on impulse or as a life plan. In adolescence, the motives for suicidal behavior appear largely interpersonal, directed at effecting change in or escape from the conflictual family or peer system. The intended communication may range from hostility to helplessness; each case has its idiosyncratic message. One thing appears clear: no other way to achieve the intended goal is apparent to the suicidal adolescent at the time the behavior is compelled.

Some adolescents engage in suicidal behavior as a consequence of severe emotional problems. Others act out of despair from severe depression, interpersonal isolation, or unexpressable rage. For most adolescents, not already defined as severely disturbed, suicide is a desperate act to end a crisis in their lives. The following sample of cases is intended to provide some insight into the motives common to completed suicide:

> A 12-year-old son of a military officer shot himself with his father's shotgun. He had been severely punished by his father after being caught playing hookey from school.
>
> The life of a 15-year-old boy was "wrapped up" in a television space show; his room cluttered with space models, posters, and related paraphernalia. When not involved with this passion, he spoke of being bored and lacking challenge. When the television show was cancelled, he wrote a suicide note and jumped 200 feet to his death from a bridge.
>
> A 15-year-old female, on alcohol and PCP, told her friend that she had "messed up [her] life," then put a shotgun to her head.
>
> A 17-year-old male argued with his girlfriend and threatened to kill himself if she walked out on him. She told him, "you're crazy." He pulled a gun out of his pocket and shot himself in the head.
>
> A 17-year-old hanged himself in a county jail cell. He had been arrested for drunk driving the night after having failed a Marine Corps test.

No vignette can portray adequately the dynamics behind such life stories. No typology can summarize succinctly the multiplicity of motives for deciding upon a self-inflicted death. Had the opportunities presented themselves, we can only wonder which and how many of these suicidal decisions might have been redirected toward alternative, life-sustaining choices. That this is possible is without question.

Interventions

It is believed by suicidologists that the decision to kill oneself is rarely lacking in clues and signs; often these are readily discernible to the trained therapist but unrecognized by those closest to the victim. It is apparent, then, that intervention begins with assessment. The ability to assess a youth at-risk depends on an awareness of signs (both verbal and behavioral) indicating that the youth may be considering suicide and an ability to overcome the feelings of anxiety, helplessness, anger, or rage that arise when confronted with a life-threatening situation. Teachers must recognize and respond to a student in pain, in spite of the myriad of other responsibilities. Peers, most often the first turned to and communicated with (Ross, 1980), must understand that what a suicidal adolescent needs is a caring friend, and that a caring friend does not hold secret a message that a friend is considering suicide. Both teachers and students fear the felt responsibility of involving themselves or of "doing the wrong thing." With education to counter commonly held myths and irrational fears (e.g., if one talks about suicide, one might suggest it . . .), knowledge about what can and should be done, and information concerning available resources for professional intervention, teachers and students can be significant gatekeepers in the intervention system (Ross, 1980).

On a more preventive level, student-peers can be taught how to identify signs and symptoms of depression and panic and about the realities of the mental health system and referrals to promote better self-assessment and problem-solving (Ross, 1985). In California and Florida, for example, state legislation has recently been passed to provide for the implementation of pilot youth suicide prevention programs in the schools to accomplish these objectives.

With awareness and education, effective steps toward intervention in and prevention of a suicidal action can be taken. Suicidal communications can be observed and taken seriously. Warning signs for increased risk of suicidal behavior can be noted and responded to. Channels of communication and empathic support can be opened and provided. Referrals for professional help can be made where both appropriate and necessary.

Individual or family therapy with the suicidal adolescent must first and foremost ensure the safety of the adolescent. Youths evaluated at high risk for continued self-harm should be considered for hospitalization. In or out of a hospital setting, however, treatment should be provided. Symptoms must be ameliorated and ongoing sources of stress must be removed or minimized. Moreover, the support of family and peers must be improved and open communication within them encouraged. Although family therapy is often the most appropriate treatment for the suicidal youngster, it may be difficult to pursue. The blame and responsibility experienced by families of suicidal adolescents may lead them to quickly cover up the open wound (Berman & Carroll, 1984) or forego treatment (Morrison & Collier, 1969). For families and peers of suicide victims, it is crucial that counseling be available to help them mourn premature death by suicide and go on with their lives.

The effectiveness of individual psychotherapy with a suicidal adolescent depends, in good measure, on the quality of the relationship established with the therapist. Whatever the procedures, the goal of therapy with a suicidal adolescent is to find non-suicidal solutions to the problem(s) presented. In this process, the more important goal of teaching effective problem-solving skills applicable to a wide range of future problem situations is sought.

As a last word, suicidal behavior--whether ending in death or renewed life-- is a communication of pain. For those we have opportunity to help, that communication commands our attention. That but one life may be renewed should be sufficient justification for the effort.

Thank you for the opportunity to testify today on the subject of teenage suicide on behalf of the American Psychological Association. If I can provide the Subcommittee with any additional information, please do not hesitate to contact me.

References

Abraham, Y., "Patterns of Communication in Families of Suicidal Adolescents," Dissertation Abstracts International, 1978, 38, 4669A.

Berman, A., & Carroll, T., "Adolescent Suicide: A Critical Review," Death Education, 1984,

Berman, A., & Cohen-Sandler, R., "Childhood and Adolescent Suicide Research: A Critique," Crisis, 1982, 3, 3-15.

Berman, A., & Tanney, B., "Taking the Mystery Out of Research," paper presented at the annual meeting of the American Association of Suicidology, Anchorage, AK, May 1984.

Berman, A., & Yufit, R., "Suicide: Is It Contagious?", Newslink, 1983, 9, 3.

Boyd, J. H., "The Increasing Rate of Suicide by Firearms," New England Journal of Medicine, 1983, 308, 872-874.

Cantor, P., "Personality Characteristics Among Youthful Female Suicide Attempters," Journal of Abnormal Psychology, 1976, 85, 324-329.

Corder, B. F., Shorr, W., & Corder, R. F., "A Study of Social and Psychological Characteristics of Adolescent Suicide Attempters in an Urban, Disadvantaged Area," Adolescence, 1974, 9, 1-16.

Garfinkel, B. D., Froese, A., & Hood, J., "Suicide Attempts in Children and Adolescents," American Journal of Psychiatry, 1982, 139, 1257-1261.

Gibson, E. A. H., "Adolescent Suicide Attempts: An Examination of Critical Factors in the School Milieu," Dissertation Abstracts International, 1982, 42, 4559B.

Healthy People. Washington, DC: U. S. Department of Health, Education, and Welfare, Public Health Service, Publication No. 79-55071, 1979.

Holinger, P., "Violent Deaths Among the Young: Recent Trends in Suicide, Homicide, and Accidents," American Journal of Psychiatry, 1979, 136, 1144-1147.

Holinger, P., & Offer, D., "Prediction of Adolescent Suicide: A Population Model," American Journal of Psychiatry, 1982, 139, 302-307.

Hynes, J. J., "An Exploratory Study of the Affective Future Time Perspective of Adolescent Attempters: Relationship to Clinical Identification of Lethality and Its Implications for Postvention," Dissertation Abstracts International, 1976, 37, 1404A-1405A.

Kandel, D. B., & Davies, M., "Epidemiology of Depressive Mood in Adolescents," Archives of General Psychiatry, 1982, 39, 1205-1212.

Korella, K., "Teenage Suicide Gestures: A Study of Suicidal Behavior Among High School Students," Dissertation Abstracts International, 1972, 32, 5039A.

Lester, D., Murrell, M. E., "The Preventive Effect of Strict Gun Control Laws on Suicide and Homicide," Suicide and Life Threatening Behavior , 1982, 12, 131-140.

Levenson, M., & Neuringer, C., "Problem Solving Behavior in Suicidal Adolescents," Journal of Consulting and Clinical Psychology, 1971, 37, 433-436.

McKenry, P., Tishler, C., & Kelly, C., "Adolescent Suicide: A Comparison of Attempters and Non-Attempters in an Emergency Room Population," Clinical Pediatrics, 1982, 21, 266-270.

Miller, M. L., Chiles, J. A., & Barnes, V. E., "Suicide Attempters Within a Delinquent Population," Journal of Consulting and Clinical Psychology, 1982, 50, 491-498.

Morrison, G. C., & Collier, J. G., "Family Treatment Approaches to Suicidal Children and Adolescents," Journal of the American Academy of Child Psychiatry, 1969, 8, 140-153.

Ross, C., "Mobilizing Schools for Suicide Prevention," Suicide and Life Threatening Behavior, 1980, 10, 239-243.

Ross, C., "Teaching Children the Facts of Life and Death: Suicide Prevention in the Schools," in M. L. Peck, N. L. Farberow, & R. E. Litman (eds.), Youth Suicide. New York: Springer, 1985, pp.

Sarles, R. M., Reynolds, B. J., & Heald, R. P., "Visual-Motor Problems of Adolescents Who Attempt Suicide," Perceptual and Motor Skills, 1979, 48, 599-602.

Schwartz, A. J., "Inaccuracy and Uncertainty in Estimates of College Student Suicide Rates," Journal of the American College Health Association, 1980, 28, 201-204.

Seiden, R. "Death in the West: A Spatial Analysis of the Youthful Suicide Rate," Western Journal of Medicine, 1983, 139, 783-795.

Seiden, R., & Freitas, R. P., "Shifting Patterns of Deadly Violence," Suicide and Life Threatening Behavior, 1980, 10, 195-209.

Shaffer, D., & Caton, C.L.M., "Runaway and Homeless Youth in New York City," Report to the Ittleson Foundation, 1984.

Stanley, E. J., & Barter, J. J., "Adolescent Suicidal Behavior," American Journal of Orthopsychiatry, 1970, 40, 87-96.

Tishler, C., & McKenry, P., "Parental Negative Self and Adolescent Suicide Attempters," Journal of the American Academy of Child Psychiatry, 1982, 21, 404-408.

Topol, P., & Reznikioff, M., "Perceived Peer and Family Relationships, Hopelessness, and Locus of Control as Factors in Adolescent Suicide Attempts," Suicide and Life Threatening Behavior, 1982, 12, 141-150.

U.S. Department of Justice, "The Unjailing of Juveniles in America: It's Your Move", 1981.

Senator SPECTER. Thank you very much, Dr. Berman.

What do you contribute the large increase in suicides to?

Dr. BERMAN. There is no one factor. Most of our research tends to implicate some breakdown in the nuclear family, some increased alienation among peers, among adolescents, and, perhaps, the cutbacks in recent years in terms of mental health resources and available funding through insurance.

Senator SPECTER. Dr. Berman, are we sure that there is really an increase in suicides, or perhaps we are keeping better track of it?

Dr. BERMAN. Well, undoubtedly we are keeping better track of it. We have a long way to go in terms of improving that. In spite of that, there are clear, undeniable increases in the certified rates, and my guess is those rates underreport suicide among adolescents by perhaps 50 percent.

Senator SPECTER. What influence, if any, does the use of drugs have on suicide? There is a line where drug usage has become much greater in the past quarter of the century.

Dr. BERMAN. We can notice parallel increases in drug use, drug abuse, and suicide rates. And again, that is corellational data; it is not implicative of cause. We know that drugs are the No. 1 method of choice for those attempting suicide but not completing. We can much more point to the prevalence of guns as the method of choice in completing suicide. We know that drug abusers share a common pathway with suicidal people in terms of being depressed, in despair, and helpless in finding effective ways to deal with life's problems.

Senator SPECTER. You talked about impulsive and career suicide. What is a career suicide person?

Dr. BERMAN. Well, Susan might be a good example of someone who, hopefully, has stopped a career of using suicidal coping strategies. She began suicide at a young age, and used that method——

Senator SPECTER. Someone who tries it a number of times over a period?

Dr. BERMAN. Yes, repetitive use of this behavior to deal with problems, either to gain attention or to communicate something.

Senator SPECTER. You say 80 percent of those who commit suicide talked about it?

Dr. BERMAN. From research studies, we estimate that from 75 to 80 percent, yes.

Senator SPECTER. If you were to give advice to parents of teenagers on a way to deal with the potential problem of suicide in their own children, what would you tell them?

Dr. BERMAN. That is a very difficult question, because oftentimes parents are imbedded in family problems, and they may be struggling with their own issues, and may not be in the best position to observe.

I think my advice is to observe closely any changes in an adolescent's behavior, and to ask questions, "well, what is going on?"

Senator SPECTER. If there is some communication about suicide in the mind of the teenager, that is a pretty good sign, from what you say?

Dr. BERMAN. Definitely. If the message is given, it is a myth to believe that we should keep our mouth shut about the subject.

Senator **Specter**. And if the teenager brings up the subject of suicide, what advice would you give to the parent, on how to respond?

Dr. **Berman**. Well, I would first say to sit down and talk about it, and give as much support, and ask questions, and do not be afraid to open the subject, and if the child goes on and communicates some thought that he or she is thinking about suicide as a way to deal with his or her problems, to recommend that perhaps together they go seek some outside help, and talk about it.

Senator **Specter**. At what stage, if you can generalize, would you recommend seeking outside help?

Dr. **Berman**. As early as possible.

Senator **Specter**. How about the question of a parent bringing up the subject of suicide? We asked that question of earlier witnesses. What would your sense of that be?

Dr. **Berman**. I think it is an appropriate topic to bring up, again, if there is some stimulus. That is, if the child says something that suggests that it is on his or her mind, or if there is some public statement about suicide, just to raise the subject in a general way to see where the child is at in his or her thinking. This is a taboo subject.

A child or adult who is feeling suicidal often feels the taboo and stigma, and is scared to bring it up, because the general feeling is "I will frighten away all these people who might care for me."

Senator **Specter**. How about the problem, or the potentiality if a parent brings it up for planting the suggestion?

Dr. **Berman**. We have absolutely no data that that happens.

Senator **Specter**. Well, aside from the data, what is your feeling for it?

Dr. **Berman**. I have never seen it to be an issue.

Senator **Specter**. You do not think it is a problem, that is a matter that is initiate, as has been suggested by reference to other people, what they apparently read in the newspapers?

Dr. **Berman**. Suicidal adolescents oftentimes are highly suggestible. One of the problems, perhaps, that you are addressing is if the subject is brought out into the open, it would be like we were planting a seed, creating an idea that they have not already thought of.

First of all, they have thought about it, it is on their mind. Second of all, what we are talking about here is an opportunity to interact on the subject, not only to bring it up, but to talk about it. That is the difference between seeing a report in the newspaper, or on television, where there would not be any interactive response.

Senator **Specter**. Where you talk about children feeling either expendable or responsible, could you amplify on that? What should parents be looking for on a feeling by the teenager being expendable?

Dr. **Berman**. Well, it is very common, at least in my clinical practice, and from others that I have talked to, that an adolescent feels responsible for the problems that the family is dealing with.

There was a report a few weeks ago that a child of a military family, it was reported widely in the press, in People magazine, where the family had some clear financial problems, and was having trouble meeting their basic needs, and the child basically said if there were one less mouth to feed perhaps things would go better. There was a clear message, that the child was feeling responsible for solving the problem, and perhaps for even causing some of the problems.

Senator **Specter**. Did that child attempt suicide?

Dr. **Berman**. That child committed suicide.

Senator **Specter**. Dr. Berman, if you had the opportunity to get Federal assistance, where would you like to see it go, on this problem?

Dr. **Berman**. If I had that opportunity, I would spend the money wisely on research, and on program development. And just perhaps integrating what we do know.

Senator **Specter**. What kind of research would you undertake?

Dr. **Berman**. I think there has to be good work on family systems, that is what happens to families when one or more family members get in trouble. There has to be good work on how these messages have been communicated by adolescents who have gone the suicidal route, in the school system, and in the family. We are taking educated guesses on the basis of individual reports; nobody has bothered to research this. There has to be clear research on what might work programmatically, educationally, and preventively.

Senator **Specter**. On that note, let us turn to Myra Herbert, who is a social work services coordinator, from Fairfax County, VA, school district, and I understand, Ms. Herbert, that you have a model program which has been developed there for the school system.

Ms. **Herbert**. Yes.

Senator **Specter**. We very much appreciate your coming, and look forward to your testimony.

STATEMENT OF MYRA R. HERBERT

Ms. **Herbert**. Thank you, Senator Specter.

I am here today to discuss the Adolescent Suicidal Prevention Program in Fairfax County. I am also here to tell you that prevention programs work, and are where more of our money and energy ought to be directed.

In September 1982 the Fairfax County School Board declared this program a priority, and asked that it be made a school and community effort. An advisory committee was convened with representation from the school system, the mental health centers, the medical association, police department, and the mental health association.

The primary goal was to give the faculty of every high school an awareness of the signs, and symptoms of children at risk, guidelines for talking with troubled children, and channels for referring them to ongoing help.

In addition, the PTA's, the Parent Teacher Associations were asked to organize correlated programs, and schools were requested to design appropriate activities for students.

It is not a simple matter to put a mandated program into a school's schedule. It is impossible to take time in the working/teaching day. We therefore had to present a didactic session in a regularly scheduled 45-minute faculty meeting, which was really a constriction.

And then following——

Senator **Specter**. A didactic session?

Ms. **Herbert**. A didactic session. We just went in and talked steadily for 45 minutes. We then held an open house the next day, with the mental health professionals from the school system and from the community, and teachers dropped in on their free periods. They did, indeed, bring in questions, concerns, many individual referrals, and often their own issues.

In the 1980–81 school year there were 11 recorded teenage suicides in the county. There were actually more that occurred during vacations or after graduation. There were several deaths recorded as accidental because of the circumstances or wishes of the family.

Senator **Specter**. Was that a very high incidence for a community of your size?

Ms. **Herbert**. Very high. The real number was over 20. The number dropped to five after the first year of this program, and fell to three last year. Staff reports that referrals from teachers have escalated.

It must be noted that the decrease is not in accordance with the national trend, which has risen steadily every year. This is a continuing program, and this year we are dealing more directly with students, looking at the social and emotional issues of their age group, and the impact on education.

We are hoping to organize a very complete awareness session for all administrators, and will continue with parents and teachers.

Adolescents need a better support system than this society is providing. In earlier generations, teens had places to turn. Extended family lived nearby, one or the other parent was usually available. There were religious affiliations, there were youth groups that reached large numbers. These kinds of support disappeared as family moved every few years, both parents began working, divorce rate rose, religious ties weakened, and youth groups seem to have gone out of fashion.

As a result, kids are bringing their problems in to school. We often hear the argument about whether this is an appropriate area for involvement of schools, but it is a pointless argument. Whether they should or not, kids are carrying their issues into the classroom, and bringing them to the school personnel they know and trust.

Schools, for many children, may also be the most constant and dependable thing in their lives. The difficulty is that schools are taking on these duties with no changes in budget, and using staff that is already heavily ladened with responsibility, and cannot cover the problems adequately. They could do a great deal more with proper funding and organization.

I am not suggesting that schools take on long-term counseling, but much more could be done effectively with short-term crises, community referral, and most of all, prevention.

I would like to ask you to take into legislative consideration the proposal that more behavioral science professionals be added to the school rosters, either administrated by schools or community mental health centers in units that operate exclusively as liaison with the local school system.

There should also be consideration for more affordable mental health care in the community. The mental health centers have long waiting lists, and private care is prohibitive for many, especially if there is no health insurance. Many group policies make absolutely no provision for outpatient mental health counseling, which is, in my opinion, the single largest need of adolescent health care. Kids need people to listen to them.

The efforts of such organizations should not only be to offer support and guidance to students, but to assist parents and families to understand the issues at stake, and to give direction in the care and growth of our young.

Suicide for the young is frequently an impulsive act, and if help is forthcoming at the right moment, the crisis passes, often never to return. There is no benefit in lamenting the state of the present age, and longing for a past one. Life has changed, and we have changed, and we must adjust. If we do not, we are placing our children at ever increasing risk, and will see more of them escaping from a life they find intolerable.

Thank you.

[The prepared statement of Ms. Herbert follows:]

PREPARED STATEMENT OF MYRA R. HERBERT

ADDRESSING THE ISSUE OF TEENAGE SUICIDE IN A PUBLIC SCHOOL SYSTEM

Fairfax County, Virginia is a four hundred square mile area outside of metropolitan Washington, D. C. It is largely affluent and middle-class with a median family income of $47,600 and a per capita income of $14,731 in 1983, but contains a variety of socio-economic and ethnic groups. In 1983, there was a minority population of 14.6 percent. Approximately 7 percent of that is black and the remainder Southeast Asian, Hispanic, and other smaller racial and cultural groups. In one high school, there are 60 different languages spoken.

The Fairfax County school system is the eighth largest in the United States. In 1984, there are 123,794 students enrolled in 162 schools. Forty-six of those schools are intermediate and high schools, some of which have populations of four and five thousand children. It is the population of these schools at which the suicide prevention program is aimed.

In the 1980-81 school year, there were eleven recorded adolescent deaths by suicide in Fairfax County. It must be understood that these were students enrolled who took their lives during the school year. There were a number of other deaths that occurred during vacations or immediately after graduation, or that were questionable enough to be recorded as accidental either because of the circumstances or because of the wishes of the family. The actual total was well over twenty, perhaps higher.

In the 1982-83 school year, in response the Fairfax County School Board elected to make a suicide prevention program a priority and requested that the effort be organized to make it a cooperative school and community program. The Department of Student Services and Special Education, an umbrella department that encompasses a wide range of related services, rapidly organized a school/community advisory committee with representation from the school system, the community mental health centers, the medical association, the mental health association, and the police department. This committee served not only as an advisory committee, but took part in the implementation of the program, organizing speakers, and contributing expertise.

It was decided that the program should reach three groups: teachers, parents, and the students themselves. Every high school and intermediate school faculty was to have an inservice program that would address depression and suicide in children. Parent Teacher Associations would be asked to organize correlated programs during the same period and all schools were asked to provide information and assistance to students. This was extended over a two-year period, 1982-83 for high schools and 1983-84 for intermediate schools.

It is not a small matter to organize a program within the confines of the school day. Schools are often criticized by outside agencies for not responding en masse to what may be viewed by some as a crucial need. If teachers were mandated to an assembly for a substantial period of time, often the suggestion, the classrooms would be unattended, and the needs of the curriculum would go unmet. Teachers must cover a specified amount of material in a specified number of hours and are held accountable for that coverage. There is the added aspect that in a county this large, all parents do not see all issues as equally important and can be vocal and critical of the school system for using time for other than academic subjects.

We therefore decided on a format that, while not ideal, could not provoke negative reaction. A regular forty-five minute faculty meeting was designated as a workshop on adolescent suicide. This was designed to be a didactic session constructed to heighten the awareness of teachers and provide guidelines for talking to students and referring problems to the proper resources within and without the school. The following day, an all-day open house was to be held in a comfortable conference room where coffee was available. Teachers were invited to drop in during their free periods to talk with the school social worker, the school psychologist, a guidance counselor, often the speaker from the previous day, and community mental health professionals as they were available. These professionals stationed themselves in schools all day. This proved to be a very effective method of communicating. Many teachers asked questions they would have hesitated to ask in a larger more formal group, many brought in their own issues, and a great number referred children they had been worried about for some time but had not identified as having a specific problem.

Guidelines were developed for the material that should be covered by any speaker to any of the groups, the signs and symptoms of depression and suicidal ideation which children are apt to exhibit. It was stressed that a single factor is usually not significant, but clusters of factors are. (See Attachment A.) Every faculty member in the county was also given a Public Affairs pamphlet that served as a ready reference. (See Attachment B.)

Community cooperation was excellent. Agencies and private practitioners gave generously of their time both to the schools and to the parent groups. The Division Superintendent gave the program full support and all schools held faculty programs. (See Attachment C.) At least three-quarters of the Parent Teacher Associations did the same. Student programs were not so widely successful. The administrators of many schools were cautious about doing something labelled "suicide" with students, many operating under the misguided notion that discussing the subject encourages the thought. Only one high school did a program that reached the entire student body. In working with students, however, one quickly realizes that they discuss the subject freely among themselves and have very little discomfort with it.

We therefore began to look at alternative methods of reaching students by a somewhat different route and reexamined those issues most mentioned as the causes of stress and unhappiness in adolescents. During 1983-84, we began to do organized programs on social and emotional issues with students. These took the form of doing in a particular high school about six hours of group work with functioning students known either by the guidance counselors or by friends to have "a problem" of some kind. Many had multiple issues but isolated one as the one to be addressed. These students then presented a panel for the entire student body, parents, and teachers at an evening session. They have offered their experiences with a particular issue and their methods of coping. Needless to say, this has been both successful and rewarding. Adolescents are extremely self-absorbed and tend to think their situations are unique. This program too has been followed by an open house the following day, and students never identified as "troubled" have shown up to discuss problems they previously thought were theirs alone. They hear the experiences and listen to the advice of their peers much better than they hear adults.

We are expanding this effort during the 1984-85 school year and hope to reach every high school. We have made a video tape of one of these panels. It is about thirty-minutes long and well worth the time it takes to view. Young people are open, honest, and spontaneous, and have proved very glad to have someone listening to them.

There is nothing more difficult to evaluate than a prevention program. There were, however, five deaths in the first year of the program and only three last year. This is again only the period during which school was in session. There were, however, also fewer deaths during holiday periods. Coincidence perhaps, but that is in inverse proportion to the national statistics. Mental health and guidance personnel in the schools report that the referral of students to their offices has risen significantly, and that faculties and administrators display an increased sophistication in identifying troubled situations. We have good reason to believe the program has had a positive impact and should be considered in other school districts over the nation.

PERSONAL VIEW

When I began on a suicide prevention program for the Fairfax County Public Schools, I reviewed the deaths that had occurred in the 1980-81 school year, the year before I joined the system. I searched school records and interviewed school personnel who had known the students. Though some of the findings were probably sociologically peculiar to Fairfax County, much of what I learned corroborated only some of what is thought to be true about suicidal young people. I have continued, with the help of the police department, who have used a survivor interview format I requested, to try to develop profiles of students at risk. The format is not intrusive and does not ask any questions the police would not usually ask; it simply insures that the important areas are covered. This was not hard research and the entire group numbers approximately thirty students. There was more information available on some than on others. From the combination of these things, I have found the following:

- Only one student over the three-year period was known to have any difficulty with the law and that was minor.
- There were more males than females.
- Most of the males used guns, but so did a significant number of the females, which is contrary to popular belief. In most cases, the guns were in the home and belonged to the immediate family.
- About five of the students were reported by family or friends to have been depressed.
- Three of the entire group had had or were presently receiving psychiatric therapy or some form of mental health counseling.
- If there were histories of physical or sexual abuse, none emerged.
- Several of the students had run away--some several times.
- Exposure to pornography did not appear to be an issue, but at least three deaths were auto-erotic hangings. One student was found with a copy of a popular magazine describing such an action. It must be added, however, that in each of these cases, the students were reported to be having difficulties of other kinds, either academically or with families.
- Family problems of some kind figured in almost all situations, although these varied greatly. About half the group had experienced parental divorce. Many of the others had conflict issues with one or the other parent and four instances of suicide occurred after a family argument.
- Of the entire group, only two students were known to have been substance abusers and only one a serious abuser. I am often distressed by the link made between suicide and substance abuse in an almost automatic manner. Young people often use substances to escape or to self-medicate, but their problems are frequently evident long before drug use begins. That fact is sometimes explained away as though substance abusing is the beginning and the end. They are all escaping, by longer or shorter routes, something they are finding unbearable.
- Of the entire group, there was not an individual who was not touched by academic issues, and on this I would like to expand. It is the students on either end of the academic spectrum who seem to have the most difficulty.

  Six students were clearly what we deem "overachievers," students with academic ability but who push themselves to a limit that is sometimes unhealthy. At the other end of the spectrum are the underachievers, and particularly those labeled as "learning-disabled." Underachievement is the single largest common factor I found in the entire group and most of those had a learning-disabled (LD) label. In an upwardly mobile, ambitious, college-bound student body, these are the children who drift to the bottom, who experience a very real sense of futility and to whom we are not paying enough attention.

We have not observed an identifiable clustering phenomenon, although I can understand the adolescent predilection for that kind of behavior. We did have three suicides in one school over a two-semester period. These were students who knew one another vaguely but were not good friends. Perhaps more importantly, all three were learning-disabled.

This has been a summary of the identified suicide population in Fairfax and the factors that appeared to be relevant. I must emphasize once again that this was not a study or an organized piece of investigation; it was done informally to give guidance in the construction of the prevention program. Students have continued to define their issues for us.

From my years of clinical practice with this age group and from the student groups held over the past year, there are numerous factors which emerge as important and should be given attention.

- Academics and academic pressure play a large part in young lives. The cost of college is overwhelming for many families and competition for scholarships is intense. Many students have jobs as well and know that colleges and universities place an importance on extracurricular activities.
- Even the bright are pushed to the limit either by their own expectations or those of their families. Parental expectations, particularly unrealistic ones, play a large part in student stress.
- For those who are not bright or who clearly have learning difficulties, life appears bleak. In a world where those with college educations are not finding jobs, those who may just graduate from high school do not see great hope.
- Learning disability creates terrible frustration and students are often given unkind labels, such as dumb or stupid. We are not as a nation spending enough money researching the process of learning.
- A death of a parent or that of a close friend is a painful loss for an adolescent and can change the course of life.
- Being in a minority is often painful and lonely.
- An alcoholic parent is a damaging burden for an adolescent.
- Having a mentally or physically ill parent will often render a child troubled and depressed for much of his or her own life.
- The American emphasis on sports and sports achievement can leave many young people feeling inadequate because they cannot perform in this sphere.
- Divorce is not good for children. It is a searing, devastating experience for most children, and there is a necessity to handle it with much more care and concern than is often being exercised. Parents need more education.
- Living in combined families is not a story-book experience. It is frought with peril and families need far more guidance than they are being given.

- Having two working parents proves to be a factor, particularly if a child is left alone a great deal or in charge of siblings. Not only is parental attention sometimes wanting, but studies on adults who have had this experience are beginning to show that it may leave an individual with unspecified fears, paranoid thinking, and a lack of social skills. Good care substitute plans deserve more consideration.
- Adjusting to a new society is sometimes mystifying to both children and their families, particularly when they are from a non-Western culture. Students get caught between parental behavioral dictates and the normal adolescent desire to emulate peers.
- Mobility and the transiency of our national population is often creating failure and misery for our young people. In Fairfax County, we have a large governmental population, foreign service and State Department families, military families, and large corporation executives who seem to move every two or three years. In addition, one of the perils of affluence is the need to move to a larger, nicer house. Divorce also often means a location change. Some of our schools empty and refill by as much as 50 percent every year. Admittedly that is not typical of the national picture, but it is not atypical either of many urban areas. Children report moving as much as nine times in fourteen years. There are two dangers in this; one is that students are constantly changing school programs and, particularly if academics do not come easily, they give up somewhere along the way. The second is that they lose their friends and this is particularly difficult after the age of twelve. Coming into a new school can be a nightmare for many, and families often report severe behavioral changes.

When one begins to realize that many of our teenagers are experiencing several of these factors at the same time, the strains upon them become evident. We must as a society look at what we are doing to our children.

PROPOSED SOLUTIONS

Adolescents need a firmer support system than they are being offered in this society. In the age when families remained intact and stayed in one place the extended family, the grandparents, aunts and uncles, cousins and siblings often performed that function. That was also an age when even small towns had organized youth groups and most families had church affiliations. Mothers remained at home and fathers did not travel greatly. Most of that kind of support system is gone for most of our young, and we have offered no substitutes.

I believe that public schools are filling much of that gap. There is little point in arguing that they should not be; children are bringing their problems into the classroom and it is often proving impossible to educate them until some of the obstacles are removed. Public schools, however, are filling the gap with inadequate preparation, personnel, or budget.

Professional staff assigned to the schools could do much to allay the problems of children and to educate parents. Many schools have mental health personnel on staff now, but these people are absorbed with the huge tasks of meeting the requirements of Public Law 94-142. And while they have skills, they do not have the time to use them and school budgets are stretched to the limit. I am not for an instant advocating that that law be in any way changed, but rather that further personnel be added, and additional federal funds be appropriated for that purpose.

I would also advocate that such staff be administrated by the school system rather than by community mental health systems. There are demands and requirements upon school systems that exterior agencies do not seem to easily comprehend. Appropriations should be made, however, clearly for this kind of supplemental program and personnel hired should be trained in the area of behavioral science and not education.

The alternative is to create a school liaison department in the community mental health centers that employs mental health professionals trained in the workings of an educational system and that develops specialized communication with the local school systems.

In either case, such a service must be further supported by more affordable mental health care in the community. The school service can function as a short-term crisis agency during the school year, but many children and families need longer term assistance. At present, there is often no where to send them, particularly if they do not have health insurance. The agencies with adjustable fee scales have long waiting lists and the cost of private practitioners is prohibitive for many. If help is not offered at the time of immediate need, the trouble is often closed over again until it erupts at another time or in another form.

The efforts of such organization should not only be to offer support and guidance to students but to assist parents and families to understand the issues at stake and give direction in the care and growth of our young. Suicide for the young is frequently an impulsive act and if help is forthcoming at the right moment, the crisis passes, often not to return.

There is no benefit in lamenting the state of the present age and longing for a past one. Life has changed, and we must adjust. If we do not, we are placing our children at ever-increasing risk, and we will see more of them escaping from a life they find intolerable.

Senator SPECTER. Thank you very much, Ms. Herbert.

You say the suicide rate went down from 25 to 3 over a 3-year span. Do you know what would be an expected or average rate of suicides for a community your size?

Ms. HERBERT. I do not. I do not know.

We have a very large student body that numbers over 123,000. That includes elementary school children.

Senator SPECTER. I am just wondering if you are under three, or if you are statistically, average three?

Dr. Berman, would you have any idea?

Dr. BERMAN. Approximately 100,000 children, you might expect to have somewhere between 3 or 4 completed suicides per year.

Senator SPECTER. Well, perhaps if you have two or three, it is perhaps not a statistic that you can gauge very accurately.

How expensive has it been for your school district to put this program into effect?

Ms. HERBERT. Not as expensive as it might be, because we have gotten a lot of voluntary help from the community. Mental health professionals including private practitioners, have given time.

Senator SPECTER. Volunteered their services?

Ms. HERBERT. Volunteered.

Senator SPECTER. Ms. Herbert, if you were to give advice to a parent about what to look for, how to prevent potential suicide in a teenage child, what would you say?

Ms. HERBERT. The first thing I would say is stay in touch with your kids, from the time they are small, if you possibly can. Listen to what they tell you, and listen quietly—I have a 16-year-old of my own, and I find that sometimes I really must steel myself to listen, and not react. It is better, however, to know what is going on with them, and have them talk to you openly, than to run from the subject or shut it off. I think that is the single most important thing that parents can do.

Senator SPECTER. So the most fundamental advice is to communicate?

Ms. HERBERT. And to hear.

Senator SPECTER. How about the subject of suicide itself?

Dr. Berman and others testified that when it is mentioned, it is a sign of a real problem. Do you agree with that?

Ms. HERBERT. Well, I work frequently with large groups of students, and it is my experience that they talk about it quite easily among themselves, and with adults, with very little of the kinds of reaction that we have as adults. I think for us it is very shocking, and it makes us feel guilty and responsible, and we wonder what we have done wrong, but kids do not experience that.

They do talk openly, and many have at least considered it at some point in their lives, as most of us have.

Senator SPECTER. Do you think most teenagers think about suicide at some time?

Ms. HERBERT. I think that everybody—probably everybody in this room has at least thought about it once, and I think children are the same way.

Senator SPECTER. Do you think everybody has thought about suicide at least once?

Ms. HERBERT. I think so.

Senator **Specter**. How about the subject of the parents bringing up the matter of suicide, do you think that would be suggestive, and harmful, or do you think it is on balance a good thing to do?

Ms. **Herbert**. I think it depends on the context in which you do it. If there is a program about suicide, or something on the media, something relevant, or something in the newspaper, to bring it up is not a bad thing.

Senator **Specter**. Do you think if there is some excuse to bring it up, it is a useful thing to do?

Ms. **Herbert**. I am sorry, I did not hear that.

Senator **Specter**. Some excuse, look for a way to bring it up, a parent sees——

Ms. **Herbert**. If you are worried about your child, sure.

Senator **Specter**. A person sees Mrs. Herbert on the television talking about it, that is an occasion to say, hey, that is a subject we ought to talk about?

Ms. **Herbert**. Well, I would say "this is apparently a very well publicized subject right now, but what do you think about it? What is going on with your friends?"

Senator **Specter**. Give an example. You are an expert in the field.

If a parent wanted to find occasion to bring this subject up, what would be an appropriate opening, and how would you suggest that a parent raise the subject?

Ms. **Herbert**. I would say, simply, "There has been a lot of media attention to suicide lately, in adolescents. It seems to be a growing national problem. What do you think about it? What do your friends think?" Or you might take some film, like "Ordinary People," which got a great deal of publicity not too long ago, and which I think many of the kids went to see, and discuss it with your child.

There are opportunities to bring up most subjects quite easily with kids, if you do indeed talk with your children, and communicate with them.

Senator **Specter**. Do you think it would be wise to look for such an opportunity to discuss the subject of suicide?

Ms. **Herbert**. I think if you are concerned about a child being depressed, or having a combination of difficulties, if there is some reason to do it, by all means.

Senator **Specter**. What is your sense as to drugs as a causative factor of teenage suicide, Ms. Herbert?

Ms. **Herbert**. I have rather strong feelings about that, some of which I think have been echoed here today. I think that too many people make a very direct association between suicide and drugs. They write off the suicide because the kid was on drugs.

My feeling about it is that kids go on drugs to self-medicate, or to escape in some way, and the signs of their problems are there long before they start drug taking, and that is where we ought to start looking.

Senator **Specter**. How about the subject of sexual abuse, do you think that is a causative factor, a significant causative factor of teenage suicide?

Ms. **Herbert**. I have not found it so. My feeling about sexual abuse is that in women it leads to difficulty with sex relations in adult life, and for men they often become sexual abusers themselves. But I have seen only a single direct association.

Senator **Specter**. To what extent would you like to see the Federal Government involved in this problem?

Ms. **Herbert**. Well, I would like to see flow-through money of some kind, if that were possible.

Senator **Specter**. What would you suggest, by way of a Federal program, if you were to fashion one, have some help on the program?

Ms. **Herbert**. I think that the most useful thing, would be the kind of thing I outlined, where either mental health appropriation was made directly to public schools, I suppose funded through States, or directly to community mental health programs, which then worked very closely with schools, with units specifically assigned to this kind of activity with the school program.

Senator **Specter**. Well, that is very helpful.

Thank you very much, District Attorney Ownby, thank you, Ms. Herbert, and thank you, Dr. Berman.

We will pursue this subject, and pay close attention to your recommendations.

[Whereupon, at 11:34 a.m., the subcommittee adjourned, subject to the call of the Chair.]

APPENDIX

ANDREW TETER #520
8601 MANCHESTER RD
SILVER SPRING, MD.
20901

October 29, 1984

Senate Subcommittee on Juvenile Justice
Senate Hart Building
Room 815
Washington, D. C. 20510

Dear sirs:

I would like to offer my views on the causes of teenage suicide, which I understand was the subject of recent hearings and therefor a subject of current interest to the Subcommitttee. I am sorry for my delay in writing this letter, and I hope it is in time for your consideration. You may include it in your hearing record if you wish although I realize this is unlikely.

Although teenage suicide is nothing new and there are probably several factors involved in teenage suicides, I think a significant factor now is that there seems to some teenagers to be no escape from a society that is becoming increasingly competitive, fast-paced, complex, materialistic, polluted, sick, morally weak, self-destructive, and unable to control its economy and technology, or from the pressures from the family and society to compete and "succeed" in this society. This realization by the teenager may be conscious or unconscious. Although we may think they are not seeing reality, perhaps they see a reality that we are not willing to see. The 1960's were a time of idealism and hope that idealism will work, and social protest was expressed in colorful, beautiful, life-affirming hippie-like styles; but the 1980's are a time of self-interest and little hope that idealism will work, with social protest expressed in black, colorless, ugly, deathly punk-like styles. I asked a very punk-style dressed fellow what his philosophy of life was, and he said "stick it up your ear." I told him my philosophy was to try to make the world a better place, and he said "What I do won't make any difference." And maybe he's right, but I'm not willing to admit that.

Children have nuclear nightmares; a large percent of teenagers expect nuclear war within 10 years; students in one high school request suicide pills to be available in case of nuclear war. We live in a society headed toward sudden death by nuclear war or slow death by pollution and destruction of the ecosystem, and simultaneous slow death of our moral strength, our social fabric, our ideals, and our spirit. It seems that competition, temptation and sensory stimulation control us, and that there is no escape. This probably seems like a living death indeed to the sensitive and idealistic side of many teenagers. The suicides of teenagers may be but a harbinger of the suicide of our society and perhaps all of humanity that threatens us.

The way out of our problems is for cooperation to predominate over competition through a massive change in our economic system and way of life, a grassroots change by us as citizens, consumers and investors, hopefully led by or at least with the cooperation of government and the economically powerful, in order to avoid a class struggle or social breakdown. Economic democracy, decentralization of economic power and responsibility, self-control over our economy, our technology,&ourselves as a society, and some simplification of lifestyle, are necessary. Cooperative business must play a large role, and by this I mean cooperatives and a strong system of cooperatives. Nationalism, capitalism and the free market will not save us. Only cooperation can save us, so we must learn to cooperate. Not just the United States, but other nations as well. America must provide moral leadership. Voluntary cooperation can be the reconciliatory meeting ground, the synthesis, between American capitalism and Soviet communism, so that both nations can each cease its kind of aggressiveness. If cooperation can only come in the face of a common enemy, then both nations must see that our common enemy is the possible self-destruction of humanity.

Sincerely,

Andrew C. Teter
Andrew C. Teter

Adolescent Suicide and the Classroom Teacher

Patrick C. McKenry
Carl L. Tishler
Karen L. Christman

ABSTRACT

Adolescent suicide is a phenomenon of epidemic proportions, constituting the third leading cause of death in this age group. Various theories of suicide are reviewed and the attention to family variables discussed. These theoretical models indicate the multidisciplinary nature of the problem — that is, that adolescent suicide requires a medical, psychological, social and educational approach to the problem. Since school plays a major role in the lives of adolescents, it offers an avenue of approach to adolescent suicide. A list of behavioral changes indicative of emotional distress is provided for teachers for use in identification and referral. Teachers should also serve an educational function. Discussion of suicide dispels myths and modifies the likelihood of an attempt. Several suggestions concerning how school personnel may intervene are provided.

INTRODUCTION

Adolescent suicide and suicide attempts constitute a major social and medical problem today. Almost 5,000 adolescents and young adults committed suicide in 1977 — an average of 13 a day. The present adolescent suicide rate has doubled in the last decade and tripled in the last 20 years while the nation's overall suicide rate has not varied much in the past half-century. Suicide is presently the third leading cause of death among adolescents; only accidents and homicides account for more deaths.[1-3]

Statistics tend to underestimate the extent of the problem. Because of religious taboos, the limitations of insurance policies and the social stigma associated with suicide, it has been estimated that as much as 50% of suicidal behavior in young persons is disguised or not reported.[4,5] Furthermore, for every successfully completed suicide by a young person, there are many more attempts — perhaps as many as 50-150 for each one successfully completed.[4-6]

THEORIES OF SUICIDE

Much controversy surrounds the etiology of suicide, particularly suicide among the young. Although there is much clinical information on suicidal attempts by children and adolescents, there have been very few controlled empirical studies of these attempts. No single theory sufficiently explains the etiology of suicide in adolescents, and research to date has produced conflicting results.[7,8]

One of the basic theories of the dynamics of suicide behavior was first formulated by Freud.[9] Applying the psychodynamic theory to adolescence, the suicidal adolescent is depicted as having experienced loss of love, deprivation and rejection in relation to important persons in his/her life. As a result, the adolescent develops feelings of anger and resentment toward these depriving persons for denying him/her affection and nurturance. These aggressive impulses toward those who are also love objects cause the adolescent to experience guilt and thereby increases his/her feelings of "badness." The adolescent's need to assuage these guilt feelings then results in self-destructive attitudes and behaviors.[10,11]

Developmental psychologists emphasize the stresses that accompany a particular stage of the life cycle. Adolescence is viewed as a time of great change, crisis and pressure with a tendency for impulsive overreaction to stressful situations. The precipitating event leading to suicide is seen by developmentalists as the culmination of a longstanding sense of entrapment and rage. The precipitating problems leading to a suicide attempt usually begin in the adolescent's environment and encompass such things as moving, changing schools, breaking up with a boyfriend or girlfriend, death of a parent or caretaker, parents' divorce or alcoholism in a family member.[6,12]

Cognitive theorists stress the importance of considering what the adolescent means when he considers his/her own death. The adolescent sometimes has a sense of personal immortality because death appears so remote. For these adolescents, death is not final, but rather a reversible process. Such a perspective is thought to be the result not only of incomplete intellectual development, but also cultural attitudes and the influence of the media which support the notion of the unreality of death. In some suicide attempts, this irrational thinking is reflected in the attempter's hope to join a lost loved one, to make an important figure love him or to represent, symbolically, a rebirth after death.[6,10]

Durkheim is foremost among those who take a sociological view of suicide — that is, the result of anomie-withdrawal, resulting in a loss of social contact and a sense of isolation from the rest of society. Such factors as family conflict and environmental changes characterize this phenomenon of anomie.[13]

Regardless of any particular theoretical orientation, much attention has been focused on family variables related to depressive and suicidal behavior in adolescents. A review of research findings indicates a relationship between adolescent suicide and a family background of marital instability, economic stress, disruption of residence and long and bitter parent-child conflict. Such family factors are thought to result in the adolescent feeling rejected, unloved and unworthy.[14,15] Several researchers have noted the frequency of depression, recent death and suicide in the family histories of depressed and suicidal adolescents. This death trend in the family histories of suicidal adolescents may indicate emotional deprivation as a result of the loss as well as an identification with the deceased and/or modeling of their means of dealing with stress.[10,12]

While these theories and research findings pertaining to adolescent suicide may appear somewhat contradictory, Smith[16] contends that they all agree on one point — that the individual's actions result from forces over which he has little or no control. In addition, certain precipitating events which can be monitored are common to all theoretical orientations. These theoretical models of adolescent suicide indicate that the problem is a multidisciplinary one that must be attacked on all fronts — medical, psychological, social and educational.

ROLE OF THE CLASSROOM TEACHER

The role of the classroom teacher is inevitably intertwined in the lives of adolescents and their families as a result of the importance of the school in the normal maturational process. The school is the natural extension of the family in the student's development. It is important that school personnel resist the notion that school life and home life are separate systems. Often teachers are the confidants of students who are under stress; sometimes they are the first outside the family to know of a problem, either by rumor, direct contact with the student or by an observed behavioral change in the student. Suicides rarely occur without warning, and teachers should be aware of both direct and indirect distress signals. Numerous behavioral changes have been associated with adolescent depression and suicide.[8,17-19] These should be observed for possible referral to the school counselor or psychologist, particularly if several are present. The teacher, however, should not over react. Not all adolescents who have these behavioral changes become suicidal; however, the majority of adolescents who have attempted suicide have evidenced such changes in behavior. These behavioral changes or cues include the following:

— a drastic change in the student's personal appearance, particularly from good to bad;

— somatic complaints — muscle aches and pains, stomachaches, backaches, headaches, diarrhea;

— inability to concentrate and problems in judgement and memory;

— a dramatic shift in the quality of school work;

— changes in daily behavior and living patterns, such as extreme fatigue, boredom, stammering and/or decreased appetite;

— social behavior changes including behavioral disorders in class, falling asleep in class, emotional outbursts possibly compounded with crying or laughter, inability to sit still, sudden bursts of energy followed by lethargy and excessive use of alcohol and drugs;

— open signs of mental illness, such as delusions and hallucinations;

— a sense of overwhelming guilt and shame;

— loss of friends.

It is also important for teachers to note that, in addition to the many personal crises that affect adolescents, some of the major life crises that occur in adults may drastically affect the psychological, familial and adaptive spheres of adolescent life. Situations that might seem relatively unimportant to the teacher could be very painful to the adolescent. The following might be a helpful checklist of life crises for teachers in referring a student to a school counselor or psychologist, particularly if they are accompanied by the aforementioned behavioral changes: (Again, teachers should be aware that the presence of these crises, even along with the behavioral changes, does not necessarily imply suicidal behavior.)[6,20-22]

— the death of a family member, close friend or relative;

— the divorce or separation of parents, siblings or relatives;

— personal problems with the law or a family member who is having present difficulty with the law;

— personal injury or chronic illness of the adolescent or close family member or friend;

— the marriage of a sibling or remarriage of a parent;

— being fired from a job or a parent being fired from a job;

— the retirement of a parent;

— a drastic change in health of a close family member or friend;

— the adolescent's own pregnancy, abortion or birth of a baby and/or that of a sibling or parent;

— a drastic change either for the better or worse in the family financial status which would include business failures, successes and foreclosures;

— a sibling leaving home for college, camp;

— outstanding or poor personal achievement by the adolescent;

— a mother beginning or stopping a work career;

— the beginning or ending of school;

— a change in residence;

— the adolescent having trouble with a teacher or teachers or a parent having trouble with his/her own boss at work;

— vacations, holidays and the first week of spring are often stressful times in the adolescent's life, the anniversary of a parent's divorce and/or birthdate;

— the death of a pet.

One of the most important psychological crises of which teachers are often aware is boy-girl relationship problems. Breaking up with one's boyfriend or girlfriend, even after dating only two or three weeks, can often precipitate acute depression on the part of the adolescent. Younger adolescents often form intense, sometimes fantasized relationships with members of the opposite sex. The disruption of these relationships can be very stressful. If the adolescent has other psychological difficulties at the same time, the breakup can be extremely upsetting.

Studies of adolescent suicide attempters indicate that school adjustment is often one of the major precipitating factors. School performance was almost uniformly poor in these samples. Poor grades, truancy and discipline problems have been found to characterize some of these adolescents. It is interesting to note that a disproportionate number of suicides occur in the spring and fall when school problems are often paramount.[16]

Thus, the classroom teacher is witness to many major indicators of student distress. But the teacher serves the educational function here as well. Frank and open discussion of suicide with students is a significant aspect of death education and should help dispel myths surrounding suicide. Discussing suicide will *not* make depressed students more inclined toward suicide; typically, they are emotionally relieved. Communication actually helps to modify the likelihood of an attempt.[16,19] However, teachers should be aware that suicide is an extremely difficult subject to discuss. Although it must not be ignored, some students may respond as non-caring, inattentive and/or giddy as a result of the anxiety raised by the subject matter. Student assemblies could also be an appropriate forum for education about suicide. Speakers in the areas of child and family development, clinical psychology, health and medicine could provide a thorough overview of the problem.

Beside the classroom teacher's primary role of referral and education in regard to suicide, the teacher should be expected to work with the counselor or school psychologist when appropriate.[10] The teacher can provide a great deal of information as a result of daily observations and interaction with the adolescent. The teacher must take all suicide threats seriously. Frequently those who threaten suicide *do* follow through; they're not just "crying wolf." Marks and Haller found little difference between those who threatened suicide and those who actually attempted it.[7] The teacher, however, must avoid the tendency to be a counselor to either student or parent. The teacher can make parents aware of any problems and acquaint them with appropriate sources of referral.

With additional training, teachers could possibly play a more active role in suicide prevention. Workshops could be undertaken to acquaint teachers with the theory and study of suicide, ie, sources of emotional and interpersonal disturbances. Teachers also could learn about community resources and techniques of referral. Along with this theoretical training, teachers might participate actively in a suicide prevention center or crisis "hotline" after special clinical training. While not all teachers have the interest, time or skills to become actively involved with this problem, it *is* important that teachers in all disciplines be cognizant of the life stresses and behavioral changes in their students and *not* pass these events off as unimportant or less important than the subject matter they are teaching.

Preparation of this manuscript was supported in part by a grant from the Children's Hospital Research Foundation, Columbus, Ohio 43205.

Reprint requests to Department of Family Relations and Human Development, 315 Campbell Hall, 1787 Neil Ave., Columbus, Ohio 43210 (Dr. McKenry).

REFERENCES

1. Holinger PC: Adolescent suicide: an epidemiological study of recent trends. *Am J Psychiatry* 135:754-756, 1978.

2. U.S. Vital Statistics: *1949-1973: Volume II-Mortality*. Washington, DC, National Center for Health Statistics, 1974.

3. U.S. Vital Statistics: *1974 and 1975: Volume II-Mortality*. Washington, DC, National Center for Health Statistics, 1978.

4. Finch SM, Poznanski EO: *Adolescent Suicide*. Springfield, Ill. Charles C Thomas Publisher, 1971.

5. Mishara BL: The extent of adolescent suicide. *Psychiatric Opinion* 12:32-37, 1975.

6. McIntire MS, Angle CR, Schlicht ML: Suicide and self-poisoning in pediatrics. *Adv Pediatr* 24:291-309, 1977.

7. Marks PA, Haller DL: Now I lay me down for keeps: a study of adolescent suicide attempts. *J Clin Psychol* 33:390-400, 1977.

8. Toolan JM: Suicide for children and adolescents. *Am J Psychother* 29:339-344, 1975.

9. Freud S: Mourning and melancholia, in Rieviere J (trans): *Collected Papers, IV*. London, Hogarth Press, 1925.

10. Gould RE: Suicide problems in children and adolescents. *Am J Psychother* 19:228-246, 1965.

11. Weiner IB; *Psychological Disturbance in Adolescence*. New York, Wiley, 1970.

12. Jacobs J: *Adolescent Suicide*. New York, Wiley, 1971.

13. Durkeim E: *Le Suicide*. Glencoe, Ill, The Free Press, 1950.

14. Corder BF, Shorr W, Corder RF: A study of social and psychological characteristics of adolescent suicide. Attempters in an urban, disadvantaged area. *Adolescence* 9:1-6, 1974.

15. Schrut A, Michels T: Adolescent girls who attempt suicide — comments on treatment. *Am J Psychother* 23:243-251, 1969.

16. Smith DF: Adolescent suicide: a problem for teachers? *Phi Delta Kappan* 57:539-542, 1976.

17. Inamdar SC, Siomopoulos G, Osborn M, et al: Phenomenology associated with depressed moods in adolescents. *Am J Psychiatry* 136:156-159, 1979.

18. McLean Hospital Children's Center: *Revised Mental Status Evaluation*. Cambridge, Mass, Harvard Medical School, 1975.

19. Weiner JM: Adolescent depression and suicide. *Clin Proc Child Hosp Natl Med Ctr* 33:123-128, 1977.

20. Brown TR, Sheran TJ: Suicide prediction: a review. *Life-Threatening Behavior* 2:67-87, 1972.

21. Kiev A: Prognostic factors in attempted suicide. *Am J Psychiatry* 131:987-990, 1974.

22. Miller JP: Suicide and adolescence. *Adolescence* 10:11-23, 1975.

Patrick C. McKenry, PhD, Assistant Professor (Corresponding author), and Karen L. Christman are both in the Department of Family Relations and Human Development, Ohio State University, 315 Campbell Hall, 1787 Neil Avenue, Columbus, OH 43210. Carl L. Tishler, PhD, Assistant Professor of Pediatrics, Department of Pediatrics, Ohio State University, Columbus, OH 43210.

California Senate Bill No. 947

CHAPTER 750

An act to add and repeal Chapter 3 (commencing with Section 10200) of Part 7 of the Education Code, relating to schools, and making an appropriation therefor.

[Approved by Governor September 12, 1983. Filed with Secretary of State September 13, 1983.]

LEGISLATIVE COUNSEL'S DIGEST

SB 947, Presley. Schools: youth suicide prevention school programs.

Current law authorizes various programs to be jointly conducted by state and local educational agencies or institutions.

This bill would provide for the development of a statewide youth suicide prevention program through the establishment of state-mandated demonstration programs in 2 designated counties. Existing suicide prevention and crisis centers located within those counties would serve as coordinating centers for the planning and development of the statewide program. Any interested county which submits a request to the State Department of Education to participate in that process by a specified date would be permitted to do so.

The bill would require the Department of Education to annually report to the Legislature regarding the status and effectiveness of the programs established pursuant to this act, and would establish a continuously appropriated Youth Suicide Prevention School Program Fund to be administered by the department for the purposes of this act. The bill would express the intent of the Legislature that $300,000 be appropriated to this fund by the Budget Act of 1984, and in the event that a lesser amount or no money is appropriated, that the Youth Suicide Prevention School Program only be implemented to the extent funds are made available. The bill would specify that none of the provisions of this act shall be construed to prohibit the department from providing financial assistance from that fund to other counties, in addition to the counties maintaining the demonstration programs, for purposes of youth suicide prevention school programs. Any county receiving such funds would be required to annually provide the Director of Finance, the Legislature, and the department with a specified accounting and program evaluation report for the previous year.

The provisions of this bill would become operative on July 1, 1984.

Article XIII B of the California Constitution and Sections 2231 and 2234 of the Revenue and Taxation Code require the state to reimburse local agencies and school districts for certain costs mandated by the state. Other provisions require the Department of

Finance to review statutes disclaiming these costs and provide, in certain cases, for making claims to the State Board of Control for reimbursement.

This bill would impose a state-mandated local program in the two counties designated to maintain the demonstration youth suicide prevention school programs pursuant to the provisions of the bill.

This bill would provide that no appropriation is made by this act for the purpose of making reimbursement pursuant to the constitutional mandate or Section 2231 or 2234, but would recognize that local agencies and school districts may pursue their other available remedies to seek reimbursement for these costs.

This bill would repeal the provisions establishing the youth suicide prevention school programs on June 30, 1987.

Appropriation: yes.

The people of the State of California do enact as follows:

SECTION 1. Chapter 3 (commencing with Section 10200) is added to Part 7 of the Education Code, to read:

CHAPTER 3. YOUTH SUICIDE PREVENTION SCHOOL PROGRAM

10200. The Legislature makes the following findings and declarations of intent:

(a) A statewide youth suicide prevention program is essential in order to address the continuing problem of youth suicide throughout the state.

(b) The suicide problem often exists in combination with other problems, such as drug abuse and alcohol use.

(c) A suicide prevention program for young people must emphasize a partnership between educational programs at the state and local levels and community suicide prevention and crisis center agencies. In order to facilitate this partnership, the Legislature finds and declares that it is of vital importance that a statewide primary prevention program be established with shared responsibility at both the state and county levels, and that this cooperation shall be a major tool in efforts to achieve the successful prevention of youth suicide.

(d) The program established pursuant to this chapter is intended by the Legislature to delegate primary responsibility for the development of a youth suicide prevention program to existing county suicide prevention agencies through the establishment of a demonstration program. The Legislature recognizes that county suicide prevention and crisis center agencies are best suited for dealing with youth suicide, as demonstrated by their past success in youth suicide prevention in California.

10205. (a) In view of the purpose and intent of this chapter, as expressed in Section 10200, highest priority for program funding under this chapter shall be designated to those counties which emphasize joint school-community youth suicide prevention programs.

(b) It is the intent of the Legislature that, to the maximum extent possible, funds made available for the purpose of this chapter shall be used to support existing programs which have demonstrated a capacity to meet the needs of young people and families in the prevention of suicide, and to support two demonstration youth suicide prevention school programs, one of which shall be located in a Northern California county, the other in a Southern California county.

(c) In view of the urgent need to begin development of a statewide youth suicide prevention program at the lowest cost to the state, and with the participation of existing suicide prevention and crisis center agencies to the greatest extent possible, and in order to ensure that the program will meet the needs of all economic and ethnic groups in California, the Legislature hereby designates San Mateo County and Los Angeles County as the locations of the two demonstration youth suicide prevention school programs.

10210. (a) The demonstration programs in San Mateo and Los Angeles counties, hereinafter referred to as "demonstration counties," shall be maintained for a period not to exceed three years from the operative date of this chapter, according to the following schedule:

(1) Planning and development of the county demonstration program shall be completed by June 30, 1985.

(2) Implementation of the county demonstration program shall be completed by June 30, 1986.

(3) Each demonstration county shall evaluate its demonstration program and submit a report of its findings to the State Department of Education, the Legislature, and the Governor on or before January 1, 1987.

10212. (a) Until October 1, 1984, any county in the state may, through its board of education, submit a request to participate in the planning and development of the statewide program to the State Department of Education.

(b) Each demonstration county shall designate the suicide prevention and crisis centers located within the county to serve as coordinating centers for the planning and development of the statewide youth suicide prevention school program. The State Department of Education, in cooperation with the designated coordinating centers, shall publish procedures for the participation of all interested counties in the planning and development of the statewide program.

(c) Planning and development of the statewide program shall be completed by June 30, 1985.

10213. No provision of this chapter shall be construed to prohibit the State Department of Education from providing financial assistance from the Youth Suicide Prevention School Program Fund to other counties, in addition to the demonstration counties, for purposes of youth suicide prevention school programs, including, but not limited to, those programs set forth in Section 10215.

10214. Funds received by a county board of education in order to carry out the purposes of this chapter shall be deposited in a separate county Youth Suicide Prevention School Program Fund established for that purpose. On or before January 1 of each year, any county which has received state funds for the purposes of this chapter shall provide the Director of Finance, the Legislature, and the State Department of Education with an accounting of expenditures for its youth suicide prevention school program and revenues received for the program from sources other than the state, and with a program evaluation report for the previous year.

10215. The youth suicide prevention school programs established pursuant to Section 10210 shall plan, fund, and implement educational programs, which may include any of the following:

(a) Classroom instruction designed to achieve any of the following objectives:

(1) Encourage sound decision making and promote ethical development.

(2) Increase pupils' awareness of the relationship between drug and alcohol use and youth suicide.

(3) Teach pupils to recognize signs of suicidal tendencies, and other facts about youth suicide.

(4) Inform pupils of available community youth suicide prevention services.

(5) Enhance school climate and relationships between teachers, counselors, and pupils.

(6) Further cooperative efforts of school personnel and community youth suicide prevention program personnel.

(b) Nonclassroom school or community based alternative programs, including, but not limited to:

(1) Positive peer group programs.

(2) A 24-hour "hotline" telephone service, staffed by trained professional counselors.

(3) Programs to collect data on youth suicide attempts.

(4) Intervention and postvention services.

(5) Parent education and training programs.

(c) Teacher training programs.

10220. The Department of Education shall enter into an interagency agreement with the appropriate county board of education for the implementation of an approved Youth Suicide Prevention School Program.

10230. The Department of Education, the county board of education, school districts, and the county suicide prevention agency in each county maintaining a program pursuant to this chapter shall establish procedures for the cooperative collection and dissemination of data regarding the implementation of the provisions of this chapter.

10235. The Department of Education shall submit an annual report to the Legislature regarding the current status and effectiveness of the programs established pursuant to this chapter.

10240. There is hereby created in the State Treasury a fund which shall be known as the Youth Suicide Prevention School Program Fund. The fund shall consist of funds appropriated by the annual Budget Act, as well as any private sector money as may be made available. Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated. The Department of Education shall administer the fund for the purposes of this chapter, and shall use no more than 5 percent of the balance of the fund to meet administrative costs.

10242. The provisions of this chapter shall become operative on July 1, 1984.

10245. This chapter shall remain in effect only until June 30, 1987, and as of that date is repealed, unless a later enacted statute, which is chaptered before June 30, 1987, deletes or extends that date.

SEC. 2. It is the intent of the Legislature that the sum of three hundred thousand dollars ($300,000) be appropriated from the General Fund to the Youth Suicide Prevention School Program Fund by the 1984–85 Budget Act. In the event that a lesser amount or no money is appropriated, it is the intent of the Legislature that the Youth Suicide Prevention School Program be implemented only to the extent that funds are made available.

SEC. 2.5. It is the intent of the Legislature that the Department of Education use a part of the amount appropriated from the General Fund to the Youth Suicide Prevention School Program Fund by the 1984–85 Budget Act for the purpose of complying with Section 10235 of the Education Code. It is also the intent of the Legislature that the costs of complying with Section 10235 of the Education Code not be included in calculating the 5-percent limitation on expenditures for administrative costs imposed by Section 10240 of the Education Code.

SEC. 3. Notwithstanding Section 6 of Article XIII B of the California Constitution and Section 2231 or 2234 of the Revenue and Taxation Code, no appropriation is made by this act for the purpose of making reimbursement pursuant to these sections. It is recognized, however, that a local agency or school district may pursue any remedies to obtain reimbursement available to it under Chapter 3 (commencing with Section 2201) of Part 4 of Division 1 of that code.

In: Golombek, H. & Garfinkel, B.D. The Adolescent and Mood Disturbance. N.Y.: International Universities Press, 1983.

CHAPTER FOURTEEN

SUICIDE IN ADOLESCENCE: PREVENTION AND TREATMENT

NORMAN L. FARBEROW

A rock song a few years ago lamented: "It's the same thing every day, well, I can't get out of bed/Too many questions that's confusing up my head." Chorus: "I got that teen-age depression, and that's what I'm talking about/If you don't know what I mean, then you better look out." The song was entitled *Teen-age Depression* and went on to deplore, with liberal use of four-letter words, the problems of family, school, and drugs.

This song reflects an alarmingly common international phenomenon of depression and suicide among the young, which is apparent in the suicide statistics for adolescents and young adults, aged 15 to 24, in many parts of the world. In Finland, for example, suicide by adolescents increased 128% between 1965 and 1973, while the rate for the entire population rose only 19% (1). During the same period, in Israel, suicide among all ages was down 3%, but 15% more young people took their own lives (1). In Japan, suicides by youth climbed 32% between 1968 and 1974, while the rate for the total population increased 24% (1). The U.S.A. saw a 70% rise from 1966 to 1974 for 15- to 24-year-olds, while the rate for the total population increased only 18% (2). Similarly, between 1965 and 1974, Canada reported a 156% increase in rate for the young group, in contrast to a 47% increase for the total population (1).

CHARACTERISTICS OF THE SUICIDAL ADOLESCENT

Who and why are the young killing themselves so readily? A search of the literature since 1970 yields at least 120 references to published reports and papers presented about suicide by young people. Assuming that this is an incomplete record of the actual number published, we can estimate that between 150 and 200 articles about suicide among the young were written during the past decade—an impressive number, averaging 17 to 22 publications annually, signifying the great concern about this problem.

I reviewed 35 reports from all parts of the world: 19 from the U.S.A., 3 from France, 2 each from Britain, Canada, and Japan, and 1 each from Australia, Germany, India, Norway, Poland, Sweden, and Yugoslavia. These articles (which are listed on pages 234–237) reported studies of adolescents and children whose suicide had been recorded in coroners' offices or who had appeared in hospitals, clinics, and schools as a result of having attempted or threatened suicide. The characteristics most frequently noted were summarized and tallied to identify the young people who are most at risk.

FEELING STATES

The most frequently mentioned feeling state was depression and hopelessness (in *12* reports),* along with emotional and physical symptoms such as sleep disturbances, changes in eating habits, trouble concentrating, fatigability, apathy, agitation, and anxiety. Aggression and hostility were noted frequently *(7)*, along with low frustration tolerance and low impulse control *(3)*. Each of the other emotional reactions, such as guilt, anger, fear, embarrassment, shame, and the general term "emotional disturbance," was cited at least once.

HISTORY

A suicidal history, of attempts or threats or suicidal ideas, was considered especially significant *(10)*. This confirms our experience that use of a suicidal mode in response to critical situations and severe interpersonal problems is likely to be repeated, often with increased potential lethality (3). A history of psychotherapy and/or hospitalization seemed significant *(5)*, but more as an indication of emotional disturbance with behavior so deviant that professional attention had been required. Suicidal behavior in the family or among friends was mentioned only once as an important identifying factor.

SOCIAL ASPECTS

The social behaviors most frequently mentioned were withdrawal and isolation, accompanied—as might be expected—by poor personal relationships *(12)*. The subjects had few contacts with their peers, and even less communication with them. They had fewer sexual contacts than is usual *(3)*, and felt uncomfortable and uneasy with the opposite sex. Their achievement in school was poor *(11)*, and they expressed frequent worries about performance in class and on examinations *(9)*. Special note was made of drug abuse and/or heavy use of alcohol, but these were reported as significant by only three investigators and apparently were not considered highly important factors in the *suicidal* activity of the young. There were infrequent mentions of a low rate of church affiliation *(2)* and membership in a low socioeconomic class *(3)*.

---

* The numbers in italics indicate the number of articles in which the characteristic was noted.

INTERPERSONAL AND DYNAMIC ASPECTS

Parental and family interaction had the greatest number of significant factors. This area of disturbed relationships with the parents, including loss or threatened loss of a parent, was considered crucial by most of the authors *(20)*. Parental discord *(11)* and even assault by and between the parents *(3)* were mentioned, along with alcoholism in the family *(4)* and parents' projecting themselves on their children *(3)*. As mentioned earlier, disturbance of this relationship affects school performance and leads to severe social and interpersonal difficulties.

Both the family and the school have thus been identified as playing major roles in the suicidal behavior of young people today.

FAMILY AND SCHOOL ROLES

The past two or three decades have seen great changes in the family and its role in society. Helen Frank commented (4): "The family reflects the cultural trend towards replacing commitment, involvement, and tenderness with self-aggrandizement, exploitativeness and titillation. The stimulation of unlimited expectations and the impossible need to validate oneself through fulfillment of them have helped change individualism to egocentricism to the detriment of the family" (p. 91). Etzioni (5) described a continually expanding divestiture of missions from the family to other institutions: education has been invested in the school, meals are obtained at fast-food outlets, economic dependence has been broken by the equal-rights movement, and the care of children has been delegated to day-care centers. Marriage is considered less important than formerly, and second marriages are touted as better than the first. The emotional bonds between husband and wife have been belittled. Shorter stated (6): "A fundamental change in family life is under way, a transition from the 'nuclear family' of the 1940s and '50s to the 'couple family' that is rapidly emerging today. . ." (p. 10).

The family thus seems to have abrogated its responsibility for preparing the child for appropriate functioning in adult society. The resulting vacuum, unfilled by other social institutions and ignored or denied by schools, has been filled instead by peers. One consequence has been a shift in emphasis to self rather than society, with responsibilities and obligations to others subordinated to gratification of self. Self-focus, self-exploration, self-expression, self-fulfillment, self-awareness, all summed up in the phrase "doing your own thing," have become not only acceptable, but desirable. Parents not only have approved this marked shift in values in their children, but in many instances have adopted the new values for themselves. Separation and detachment from and by the children have left the latter with a sense of alienation, lack of continuity, and instability. The feeling of security that comes from a sense of belonging to a nurturing family environment within which supportive learning could take place has been lost. The affluent society has contributed to this state by providing financial and social independence before youth is ready and can handle them. The family role has been further changed by the women's-liberation movement, as increasing numbers of women have moved out of the home and back into the work force. Although this adjustment is seen as long overdue, there have been no compensatory movements to make up for the loss of the mother in the home. Adjustment to this shift is still in process, with many more changes undoubtedly yet to come.

Repschitz (7) listed several features of today's society that contribute to the alienation and loneliness characterizing our youth. He noted how parents have provided an unfortunate example by their ready use of drugs to alleviate any anxiety or stress, and by behaving as if these were feelings to be avoided at all costs. Drugs of many kinds, especially analgesics, tranquilizers, and soporifics, can be found in most households, their easy availability facilitating impulsive ingestion. Repschitz deplored the lack of inhibitions and discipline that characterize communication today in what he calls an erroneous interpretation of free expression. He stated that the young have seized upon what they consider the right, if not the obligation, to express themselves when the impulse occurs, regardless of time, place, and appropriateness. The result is narcissism and an uncontrolled release of instinctual drives. This tendency has served to drive the wedge even further between youth and adult, since the adults were educated to inhibit and control their free expression, whereas today's young are not.

It is also believed that excessive sexual license has further increased alienation among the young (7). As sexual intimacy has lost its sense of warmth and tenderness, under the bombardment of advertising, television, "pop stars," pornography and X-rated films, mechanized sex has become a bore. Increased rates of separation and divorce, especially among teenagers, support this conclusion. Along with loss of meaning in life has been the feeling that life at present is uncertain and tenuous in the extreme. The young have had to deal with the nuclear age and its potential for instant termination, with a callousness for life exemplified by extermination camps and indifference to "the boat people," and to a marked increase in violence and murders, all leading to a feeling of living on the brink of disaster; life has become cheap and readily expendable.

Repschitz (7) and Weissman (8) feel that physical changes too have contributed to the increase in suicides by youth. Physical development occurs earlier today, as a result of improved nutrition, medical care, social services, and economic conditions. At the same time, the age of entrance into gainful employment and independence has been delayed. The speed of attainment of physical maturity has not been paralleled by emotional growth, however, causing increasing disparity between physical capability and the emotional maturity required to appreciate the consequences of one's actions. Suicide among children below 15 years of age is also reported to have increased, although the numbers remain comparatively small, and their validity probably is even more tenuous than the numbers and rates for any other age group (9-11).

The schools also are not meeting the needs of today's youth. Difficulties in learning lead to self-defeat and frustration, resulting in poor achievement, thus creating a vicious cycle (12). Rohn, Sarles, Kenny, Reynolds, and Heald (13) reported that of 65 young people who had attempted suicide, 75% had poor scholastic records, 35% were truants, 35% had chronic discipline problems, and 19% failed one or more grades. Although the school's immediate responsibility is to impart information on specified subjects, it is also a primary source for models of social adaptation. Introduction of the primarily youth-centered problem of drug abuse caused frantic panic reactions on campuses as the schools tried to cope. The problem of drugs and alcohol brought in by a relatively small proportion of students produced an atmosphere of massive chaos and confusion, suspicion and mistrust; undercover agents, deception, and trickery were introduced, and violence and cheating became common experiences of school life. The students became confused, bitter, and resentful.

In short, suicide by the young is a major, increasingly visible problem that is highly influenced by problems in the family, school, community, and society.

TREATMENT PROGRAMS

Glaser's assertion (14) that treatment of suicidal adolescents requires an eclectic, flexible approach, using all available methods and resources separately, sequentially, and in conjunction, is unquestionably fitting. A comprehensive program should be widespread, made up of several special programs. It should include not only crisis intervention, "the secondary area" in public-health terminology, but also primary care activities aimed at preventing the event; and tertiary care, with follow-up, hospitalization when necessary, and rehabilitation to help the person recover from the suicidal behavior and adjust better to his environment.

Primary prevention requires removal or modification of causes or precipitants so that the condition does not occur; this means getting at the basic structure of social and family life (8). To be effective, it should aim appropriately at educating parents in mental-health principles of child-rearing, with special emphasis on the development of identity, self-esteem, basic trust, and feelings of self-worth, and in the need for responsibility to others as well as oneself. Social changes, such as reducing the divorce rate, re-emphasizing the family as a nuclear unit, increasing communication between family members, and re-establishing the family as a primary support, are further desirable goals, but their achievement will require major cultural reorganization.

Other more immediate, primary preventive methods should include programs that focus on early identification of potential suicides within high-risk groups, and then intervention with information, modeling, involvement, close and repeated association, and continued evidence of caring. Psychiatric and delinquent youth are examples of groups within which the potential for suicide needs to be assessed constantly, and programs of prevention initiated (10, 15).

Both primary and secondary efforts are necessary in the schools. A comprehensive program of prevention directed toward teachers as well as students should aim at educating both groups to serve as "gatekeepers." They should be trained to recognize the various guises in which suicide might appear, and to reduce the taboos around the event; thus the usual reactions (i.e., denial, embarrassment, and shame) need not prevent a distressed child from expressing his wish for help, or potential rescuers from responding to his communications. Any form of deviant behavior should be investigated immediately and followed up (16).

One such program has been initiated successfully in the Suicide Prevention and Crisis Intervention Center at San Mateo, near San Francisco. Ross and Lee (17) wrote two brochures, one directed to school guidance personnel and teachers, the other to students. For the students, the authors included six warning signs: suicide threats, statements revealing a desire to die, previous suicide attempts, sudden changes in behavior, depression, and making final arrangements. In visits to schools, professionals from the Center meet the staff and students to present information on suicide, reasons for concern, and what to do about it. The critical points are emphasized many times: listen, without being judgmental; do not help the person deny problems; indicate interest and concern; enlist help; re-establish communication with significant others; and use professional help, if necessary, for evaluation. A film, *Suicide at 17*, has been produced especially for school personnel; it details the case of a school student who became suicidal and killed himself.

The principles and procedures developed for school personnel are also useful for most other gatekeeper groups, such as physicians, police, and clergy, and social organizations. It is most helpful to reassure such groups that they are not asked to be therapists or to assume full responsibility for helping, which is often a frightening obligation; rather, their primary purpose should be early identification, support through evidence of caring, and referral to trained persons when necessary.

Secondary prevention services, aimed at reducing any disability as soon as possible after its onset, are provided by suicide-prevention centers, crisis centers, community mental-health centers, and hospital emergency rooms; adolescents may use these services directly or be referred by others in the community. Physicians, clergy, teachers, police, and other individual or group gatekeepers play a major role in this phase, serving as first contacts with the community's social services.

Many adolescents identify themselves as suicidal through a suicide attempt or threat, or through severe depression, withdrawal, hopelessness, and other disturbed behavior. The first objective of treatment is survival beyond the crisis. Principles of treatment to cope with a crisis experienced by an adolescent are the same as those applied to any other age group: establishing rapport and trust, focusing, assessing the potential for suicide, evaluating resources, and making recommendations for disposition and treatment. Details of development for each step are included in the Los Angeles Suicide Prevention Center Manual (18).

"Hot lines" and "crisis lines" for youth are useful in encouraging direct contact from distressed persons. A special feature of these may be the use of workers who are young themselves; they are carefully selected, usually from among university graduates, or from colleges where psychology, nursing education, premedical, and other such courses credit the experience. Training is by professionals, with emphasis on the principles of interviewing, including establishing rapport, genuineness, and empathy, and the recognition of severe disturbances that require professional help. The extent of personal involvement is carefully monitored to avoid the common pitfall of doing too much, e.g., the Magna Mater Complex ("I shall take care of all your problems") and the Jehovah Complex ("I'm the only one who can handle this difficult case") are described as reactions to be avoided. Youthful personnel of suicide-prevention and crisis centers are also excellent representatives in work with schools and other youth organizations.

Tertiary prevention with suicidal youth involves long-term rehabilitation, and usually requires the full range of therapeutic modalities. Toolan (11) feels that every young person who attempts or threatens suicide should be evaluated thoroughly. Pfeffer (19) stated that the psychiatric hospital treatment of suicidal young children is lengthy, and requires the participation of the family. If a child cannot return home because of insufficient changes in the family and environment, it may be necessary to arrange for residential care elsewhere. Other outpatient and inpatient therapies may involve group, family, and psychopharmacologic techniques. However, no one method can be preferred over all others, for, as Pfeffer pointed out (10), there have been few systematic long term prospective studies of children who, initially suicidal, have been followed up through adolescence into adulthood for the purpose of evaluating the benefits of various therapies.

No matter what the treatment modality—individual, group, or family, inpatient or outpatient, prolonged or brief—the therapist's primary objective is to save the person's life, and then to help him change his feelings (and his environment, where feasible) so that he can function comfortably and productively. Severe personality disturbance makes the task much harder.

Suicidal behavior in youth is nearly always a sign of poor communication with parents, and opening the lines of communication is fundamental (20). Glaser (14) emphasized the need to analyze the child's self-image carefully, to help separate those elements that are alterable from those that are not. If medications are used, they must be carefully monitored to ensure they are taken correctly, and the patient must be warned of any possible side-effects, such as dryness of the mouth or drowsiness.

Family therapy seems especially useful, judging by the extensive contribution to suicidal behavior that has been attributed to the family. Richman (21), reporting his use of family therapy in the treatment of many suicidal persons, described the tight defense a family develops against the anxiety produced by suicidal behavior of one of its members. This "closed family system" is characterized by four features: disruption of ties to other institutions by constriction and isolation, forcing its members to rely on each other for satisfying their needs; prohibition of intimacy with non-family members by treating any outside encroachment as an enemy; emotional isolation of the suicidal person by alienating that person both from outside contacts and within the family; and domination by a fragile family member, as in the case of parents who are weak, in need of protection, or even potentially suicidal themselves. The family may not be closed at all times; it may vary between open and closed states according to conditions of stress and crisis.

Pluzek (22) uses a direct social-modification approach in her program in Cracow, Poland. Youth (mostly between 15 and 20 years old) who have attempted suicide are invited to join a club, and are seen in group treatment. There are at least five kinds of groups, depending on the patient's needs: insight therapy, learning work habits, organizing leisure time, stimulation of interests, and relaxation therapy, including sports. She reported success with all of the procedures, but admitted there are some chronic patients with a long history of maladjusted behavior who remain at high risk long after the attempt at suicide. Here crisis intervention is not enough: treatment must be continued to help these young people not only through the suicidal situation, but also through the complicated process of developing a more mature personality.

CONCLUSION

Although the long-range goals of altering society and schools are slow in arriving, change in secondary and tertiary processes for suicide prevention can be initiated at any time. Treatment takes many forms, the basic ingredients being the attitudes and motivations of professionals and the public. With society alerted to the fact that the young are killing themselves at an alarming and ever-increasing rate, both the motivation and the opportunity emerge for wide-ranging programs of prevention and treatment.

The objective common to all such programs would be to overcome the lethal combination of feelings of worthlessness, helplessness, and hopelessness; thus, the essential ingredient of all approaches is the development of interest and caring for each youngster who despairs, a factor proven fundamental and effective in preventing suicide.

REFERENCES

(*see also* Studies Reviewed, pages 234–237)

1. World Health Organization (1968–78), *World Health Statistics Annual, 1965–76*, Vol. 1: *Vital Statistics and Causes of Death.* Geneva: W.H.O.
2. U.S. National Center for Health Statistics (1968–78), *Vital Statistics of the United States, 1966–74*, Vol. 2: *Mortality*, part A. Washington, D.C.: U.S. Govt. Printing Office.
3. Worden, J. W. (1976), Lethality factors and the suicide attempt. In: *Suicidology: Contemporary Developments*, ed. E. S. Shneidman. New York: Grune & Stratton, pp. 139–162.
4. Frank, H. (1977), Survival tactics. *J. Curr. Social Issues*, 14:86–92.
5. Etzioni, A. (1977), The family: is it obsolete? *J. Curr. Social Issues*, 14:4–9.
6. Shorter, E. (1977), Changing from nuclear nest to intimate couple. *J. Curr. Social Issues*, 14:10–13.
7. Repschitz, D. H. (1978), Correlation between generation gap and self-aggression in the young. In: *Aspects of Suicide in Modern Civilization*, ed. H. S. Winnick & L. Miller. Proceedings of the 8th International Congress on Suicide Prevention and Crisis Intervention, Jerusalem, Israel, Oct. 1975. Jerusalem: Academic Press, pp. 193–198.
8. Weissman, M. M. (1976), Self-destructive youth: a problem in primary prevention. *Curr. Concepts Psychiatry*, 2:2–4.

9. Aleksandrowicz, M. K. (1975), The biological strangers: an attempted suicide of a 7½-year-old girl. *Bull. Menninger Clin.*, 39:163-176.
10. Pfeffer, C. R. (1979), Unanswered questions about childhood suicidal behavior: a review. In: *Proceedings of the 10th International Congress on Suicide Prevention and Crisis Intervention*, Ottawa, June 17-20, 1979. Ottawa: International Association for Suicide Prevention (Canada), pp. 430-434.
11. Toolan, J. M. (1978), Therapy of depressed and suicidal children. *Am. J. Psychother.*, 32:243-251.
12. A-Davidson, R. (1979), Public interest: private grief. The case of adolescent suicide. *J. Curr. Adolesc. Med.*, 1:28-35.
13. Rohn, R. D., Sarles, R. M., Kenny, T. J., Reynolds, B. J., & Heald, F. P. (1977), Adolescents who attempt suicide. *J. Pediatr.*, 90:636-638.
14. Glaser, K. (1978), The treatment of depressed and suicidal adolescents. *Am. J. Psychother.*, 32:252-269.
15. Paulson, M. J., Stone, D., & Sposto, R. (1978), Suicide potential and behavior in children ages 4 to 12. *Suicide Life Threat. Behav.*, 8:225-242.
16. Sartore, R. L. (1976), Students and suicide: an interpersonal tragedy. *Theory into Practice*, 15:337-340.
17. Ross, C. P. & Lee, A. R. (1977), *Suicide in Youth—A Guide for School Personnel.* West Point, Fla.: Merck, Sharp & Dohme.
18. Farberow, N. L., Heilig, S. M., & Litman, R. E. (1968), *Techniques in Crisis Intervention: A Training Manual.* Los Angeles, Calif.: Suicide Prevention Center.
19. Pfeffer, C. R. (1978), Psychiatric hospital treatment of suicidal children. *Suicide Life Threat. Behav.*, 8:150-160.
20. Glaser, K. (1971), Suicidal children—management. *Am. J. Psychother.*, 25:27-36.
21. Richman, J. (1979), Suicide and the closed family system. In: *Proceedings of the 10th International Congress on Suicide Prevention and Crisis Intervention*, Ottawa, June 17-20, 1979. Ottawa: International Association for Suicide Prevention (Canada), pp. 329-332.
22. Pluzek, Z. (1978), Efficacy of the treatment program of attempted suicide among youth. In: *Proceedings of the 9th International Congress on Suicide Prevention and Crisis Intervention*, Helsinki, June 20-23, 1977, ed. V. Aalberg. Helsinki: Finnish Association for Mental Health, pp. 114-118.

STUDIES REVIEWED

AUSTRALIA

Connell, H. M. (1972), Attempted suicide in school children. *Med. J. Aust.*, 1: 686-690.

BRITAIN

Shaffer, D. (1974), Suicide in childhood and early adolescence. *J. Child Psychol. Psychiatry*, 15:275-291.

White, H. C. (1974), Self-poisoning in adolescents. *Br. J. Psychiatry*, 124:24-35.

CANADA

Garfinkel, B. D., Chamberlain, C., & Golombek, H. (1979), Completed suicide in Ontario youth. In: *Proceedings of the 10th International Congress on Suicide Prevention and Crisis Intervention,* Ottawa, June 17–20, 1979. Ottawa: International Association for Suicide Prevention (Canada), pp. 126–131.

Garfinkel, B. D., Froese, A., & Golombek, H. (1979), Suicidal behavior in a pediatric population. In: *Proceedings of the 10th International Congress on Suicide Prevention and Crisis Intervention,* Ottawa, June 17–20, 1979. Ottawa: International Association for Suicide Prevention (Canada), pp. 305–312.

FRANCE

Davidson, F. & Choquet, M. (1976), (Epidemiological study of suicide by adolescents: comparison between primary suicide and repeated attempts. English abstract.) *Rev. Epidemiolog. Sante Publ.*, 24:11–26.

Duché, D. J. (1974), (Attempts at suicide by adolescents. English abstract.) *Rev. Neuropsychiatr. Infant.*, 22:639–656.

Moullembe, A., Tiano, F., Anavi, G., et al. (1973–74), (Essay on suicide: a theoretical and a clinical approach. English abstract.) *Bull. Psychol.*, 27:804–943.

GERMANY

Hartmann, K. (1970), (Contribution to the psychopathology of minors with suicidal tendencies. English abstract.) *Prax. Kinderpsychol. Kinderpsychiatr.*, 19:168–170.

INDIA

Sathyavathi, K. (1975), Suicide among children in Bangalore. *Indian J. Pediatr.*, 42:149–157.

JAPAN

Iga, M. & Ohara, K. (1967), Suicide attempts of Japanese youth and Durkheim's concept of anomie: an interpretation. *Hum. Org.*, 26:59–68.

Ishii, K. (1972), Backgrounds and suicidal behaviors of committed suicides among Kyoto University students. *Psychologia*, 15:137–148.

NORWAY

Madland, N. (1972), (Problems concerning suicide amongst psychiatric patients in childhood and adolescence. English abstract.) *Tidsskr. Nor. Laegeforen.*, 92:1190–1193.

POLAND

Pluzek, Z. (1978), Efficacy of the treatment program of attempted suicide among youth. In: *Proceedings of the 9th International Congress on Suicide Prevention and Crisis Intervention,* Helsinki, June 20–23, 1977, ed. V. Aalberg. Helsinki: Finnish Association for Mental Health, pp. 114–118.

SWEDEN

Otto, U. (1978), Suicidal behavior in childhood and adolescence. In: *Proceedings of the 9th International Congress on Suicide Prevention and Crisis Intervention,* Helsinki, June 20-23, 1977, ed. V. Aalberg. Helsinki: Finnish Association for Mental Health, pp. 119-126.

UNITED STATES

Cantor, P. (1976a), Frequency of suicidal thought and self-destructive behavior among females. *Suicide Life Threat. Behav.*, 6:92-100.

Cantor, P. (1976b), Personality characteristics found among youthful female suicide attempters. *J. Abnorm. Psychol.*, 85:324-329.

Corder, B. F., Page, P. V., & Corder, R. F. (1974), Parental history, family communication and interaction patterns in adolescent suicide. *Fam. Therapy*, 1: 285-290.

Hendin, H. (1976), Growing up dead: student suicide. In: *Suicidology: Contemporary Developments*, ed. E. S. Shneidman. New York: Grune & Stratton, pp. 317-334.

Knott, J. E. (1973), Campus suicide in America. *Omega: J. Death Dying*, 4:65-71.

Korrella, K. (1972), Teen-age suicidal gestures: a study of suicidal behavior among high school students. *Dissert. Abstr. Int.*, 32(9-A), March, p. 5039.

Marfatia, J. C. (1975), Suicide in childhood and adolescence. *Child Psychiatry Q.*, 8:13-16.

McIntire, M. S. & Angle, C. R. (1975), Evaluation of suicide risk in adolescents. *J. Fam. Pract.*, 2:339-341.

Peck, M. L. & Litman, R. E. (1974), Current trends in youthful suicide. In: *Suicide and Blacks: A Monograph for Continuing Education in Suicide Prevention*, ed. J. Bush. Los Angeles, Calif.: Charles R. Drew Postgraduate Medical School.

Peck, M. L. & Schrut, A. (1971), Suicidal behavior among college students. *Health Serv. Ment. Health Adm.*, 86:149-156.

Pfeffer, C. R. (1979), Unanswered questions about childhood suicidal behavior: a review. In: *Proceedings of the 10th International Congress on Suicide Prevention and Crisis Intervention,* Ottawa, June 17-20, 1979. Ottawa: International Association for Suicide Prevention (Canada), pp. 430-434.

Ross, C. P. & Lee, A. R. (1977), *Suicide in Youth—A Guide for School Personnel.* West Point, Fla.: Merck, Sharp & Dohme.

Sanborn, D. E., III, Sanborn, C. J., & Cimbolic, P. (1973), Two years of suicide: a study of adolescent suicide in New Hampshire. *Child Psychiatry Hum. Dev.*, 3:234-242.

Sartore, R. L. (1976), Students and suicide: an interpersonal tragedy. *Theory into Practice*, 15:337-340.

Schneer, H. I., Perlstein, A., & Brozovsky, M. (1975), Hospitalized suicidal adolescents: two generations. *J. Am. Acad. Child Psychiatry*, 14:268-280.

Stanley, E. J. & Barter, J. T. (1970), Adolescent suicidal behavior. *Am. J. Orthopsychiatry*, 40:87-96.

Teicher, J. D. (1972), Children and adolescents who attempt suicide. In: *Self-destructive Behavior: A National Crisis,* ed. B. Q. Hafen & E. J. Faux. Minneapolis: Burgess, pp. 119-129.

Toolan, J. M. (1975), Suicide in children and adolescents. *Am. J. Psychother.*, 29:339-344.

Weissman, M. M. (1976), Self-destructive youth: a problem in primary prevention. *Curr. Concepts Psychiatry*, 2:2-4.

YUGOSLAVIA

Šojleva, M. (1974), (Psychological examination of adolescents with suicidal attempts.) *Socijalna Psihijatrija*, 2:145-150. English summary (1975), *Psychol. Abstr.*, 54:687-688.